FIRST BUSINESS SESSION OF THE EMPOWERED ACTION GROUP ON POPULATION STABILISATION

JUNE 18, 2001 VIGYAN BHAWAN

INDEX

Section 1

Constitution of the

Empowered Action Group (EAG)

No. N.23011/32/2000-Ply
Government of India
Ministry of Health and Family Welfare
Department of Family Welfare

Nirman Bhavan, New Delhi.
Dated the 20th March, 2001.

ORDER

In order to facilitate the preparation of area-specific programmes, with special emphasis on states that have been lagging behind in containing population growth to manageable limits the Government of India has decided to constitute an **Empowered Action Group** in the Ministry of Health and Family Welfare with immediate effect. The Group will also concentrate on involving voluntary associations, community organisations and Panchayati Raj Institutions. It will explore the possibility of expanding the scope of social marketing of contraceptives in a manner that makes them easily accessible even while raising awareness levels. The following will be members of the Group: -

Minister for Health and Family Welfare	**Chairman**
Minister of State for Health and Family Welfare	**Vice Chairman**
Secretary, Deptt. of Family Welfare	Member
Secretary, Deptt. of Health	Member
Secretary, Deptt. of Indian Systems of Medicine and Homeopathy	Member
Secretary, Deptt. of Elementary Education & Literacy	Member
Secretary, Deptt. of Women and Child Development	Member
Secretary, Deptt. of Rural Development	Member
Director General of Health Services	Member
Project Director, National AIDS Control Organisation	Member
Principal Secretary/Secretary (Health & Family Welfare) of the States of UP, MP, Bihar, Rajasthan, Orissa, Chhatisgarh, Uttaranchal and Jharkhand	Member
Additional Secretary, Department of Expenditure, Ministry of Finance	Member
Advisor(Health), Planning Commission	Member

Joint Secretary & Financial Adviser, Ministry of Health and Family Welfare	Member
Joint Secretary (Reproductive and Child Health), Department of Family Welfare	Member
Director General, Indian Council of Medical Research	Member
Director, National Institute of Health and Family Welfare, New Delhi	Member
Director, International Institute of Population Sciences, Mumbai	Member
Executive Director, Voluntary Health Association of India	Member
President, Family Planning Association of India	Member
Joint Secretary (Policy), Department of Family Welfare -	**Convenor**

2. The **Terms of Reference** of the Empowered Action Group(EAG) shall be as under:-

(i) To formulate programmes aimed at achieving the socio-demographic goals enumerated in National Population Policy 2000 in the areas/states that have been lagging behind in containing population growth. The following action will be taken in this regard :

a) To introduce information technologies and management information systems, at district and sub-district levels in these States, to monitor availability and access to contraceptives, drugs and vaccines, as well as to services, in the near and far flung areas within these states;

b) To improve the existing systems for logistics in these states, to ensure proper cold chain arrangements, timely delivery of supplies and equipment, adequate inventory control and timely reporting of stock positions;

c) To implement the paradigm shift in the management of programmes for population stabilization by incorporating diverse health care providers :

- Accrediting private medical practitioners and assigning to them defined satellite populations for whom they will provide basic health services;
- Reviving the system of licensed medical practitioner, who can provide specific clinical services, after appropriate certification;
- Involving the non-medical fraternity;
- Creating a network in these states of all manner of health facilities, identified by a common logo, to provide reproductive and child health services free to any client;

- Forming a consortium of the voluntary sector, the non-government sector and the private corporate sector to aid government in the provision and outreach of basic reproductive and child health care and basic education;
- Mainstreaming Indian Systems of Medicine.

d) To position appropriate health care providers at every CHC/PHC/Sub-Centers in these states, to target 24 hour service delivery at the primary health centers in these states;

e) To pilot convergence of service delivery at village levels, through self help groups, with the help of the voluntary sector and the non-government organisations;

f) To finalise a targeted campaign for information, education and communication in these states that will involve the community, civil society, opinion leaders and political representatives, from village levels upwards, for dissemination of advocacy, information and communication, in these states;

g) To energize the existing systems of referral transportation, training of dais, and quality of reproductive health care through a public private partnership;

h) To put in place intensive monitoring systems, inclusive of concurrent evaluations and reliable, detailed household and facility surveys, through professional agencies;

i) To ensure implementation of district planning through the community needs assessment reporting from each of the districts, in these states;

j) To align program and project delivery with advances in current technologies in reproductive research;

k) To pioneer projects for extending wider coverage and outreach of basic health care services through the active participation of non-government organisations, the voluntary sector and the private corporate sector, particularly in the area of referral transportation and improving quality of care.

(ii) To assist the concerned State Governments in achieving the goals set in their State Population Policy.

(iii) To devise ways for meaningful involvement of voluntary associations, community organisations and Panchayati Raj Institutions.

(iv) To explore the possibility of expanding the scope of social marketing of contraceptives in a manner that makes them easily accessible even while raising awareness levels.

3. In the matters relating to the grant of TA/DA to the Non-official Members of the EAG for attending meetings etc. of the Group or its

sub-groups, the expenditure will be borne by the Department of Family Welfare and the necessary payment shall be made as per the rules governing grant of TA/DA to Non-Official Members. In the case of Official Members, they will draw TA/DA from their respective Offices.

(Smt. Meenakshi Datta Ghosh)
Joint Secretary to the Government of India

To

Cabinet Secretary

Secretary, Deptt. of Family Welfare

Secretary, Deptt. of Health

Secretary, Deptt. of ISM&H

Secretary, Deptt. of Elementary Education & Literacy

Secretary, Deptt. of Women and Child Development
Secretary, Deptt. of Rural Development

Additional Secretary & Project Director, NACO

Principal Secretary/Secretary(Health & FW) Bihar

Principal Secretary/Secretary(Health & FW) Chhatisgarh

Principal Secretary/Secretary(Health & FW) Jharkhand

Principal Secretary/Secretary(Health & FW) Madhya Pradesh

Principal Secretary/Secretary(Health & FW) Orissa

Principal Secretary/Secretary(Health & FW) Rajasthan

Principal Secretary/Secretary(Health & FW) Uttaranchal

Principal Secretary/Secretary(Health & FW) Uttar Pradesh

Additional Secretary, Deptt. of Expenditure, Ministry of Finance

Advisor Health, Planning Commission

Director (Mrs. Pushpa Subramanium), PMO

Joint Secretary(P), Deptt. of F.W.

Joint Secretary & FA, Ministry of Health & F.W.

Joint Secretary(RCH), Deptt. of F.W.

Director General of Health Services

Director General (ICMR)

Director, NIHFW, New Delhi.

Director, IIPS, Mumbai.

Chairman, Voluntary Health Association of India

President, Family Planning Association of India

(Smt. Meenakshi Datta Ghosh)
Joint Secretary to the Govt. of India

Copy to:-

1. PS to HFM
2. PS to MOS(HFW)

(S.C. Srivastava)
Director(Policy)

Section 2

Agenda Notes

First Business Session of EAG

EMPOWERED ACTION GROUP (EAG)
FIRST BUSINESS SESSION

VIGYAN BHAWAN, NEW DELHI
18TH JUNE, 2001

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EMPOWERED ACTION GROUP (EAG)
FIRST BUSINESS SESSION

VIGYAN BHAWAN, NEW DELHI
18TH JUNE, 2001

AGENDA NOTES

1. INTRODUCTION

1.1 The Census of India 2001, the quinquennial National Family Health Surveys (1992 – 93 and 1998 – 99), the reports of the National Sample Survey Organisation (NSSO), the district survey reports, the facility survey reports, and several professional studies clearly demonstrate that 50+ years of planned development in India have yielded substantial differences between states in the achievement of basic demographic indices. There are wide inter – state, male – female and rural urban disparities in outcomes and impacts. States identified as heavily deficient in provisioning for access, coverage and outreach of basic primary and reproductive health care have been included[1] for focussed attention by the Empowered Action Group (EAG), notified in March 2001[2].

1.2 The most comprehensive international deliberation to date on population and development has been the International Conference on Population and Development (IPCD) at Cairo, September, 1994. India participated in the discussions, and was a signatory to the Programme of Action. At the ICPD it was recognised that invariably, coercion, targets and incentives have no lasting effective role in impacting the growth of population. A more appropriate approach was to concentrate on providing accessible good quality, holistic health services for women and children, with reproductive health care being just one aspect of this larger focus. By signing the Cairo Convention, India committed itself to this wider programme of improving holistic health services, especially at the primary and first referral levels. The National Population Policy, 2000 and the Empowered Action Group (EAG) are focussing on why that improvement did not occur across the land.

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[1] Bihar, Jharkhand, Uttar Pradesh, Uttaranchal, Rajasthan, Orissa, Madhya Pradesh and Chhatisgarh.

[2] One of the structures set up by Government of India in pursuance of the National Population Policy, 2000.

1.3 A comparison of some of the key parameters within the EAG states demonstrates significant variation between the eight states.

Table-1 : Some Key Indicators : India and EAG States

Indicator / parameter	India	EAG States							
		Bihar	Jhar-khand	MP	Chhatis-garh	Orissa	Rajas-than	UP	Uttar-anchal
A: Census 2001 estimates (Provisional results)									
Census 2001 population (in million)	1027	82.88	26.91	60.38	20.79	36.71	56.47	166.05	8.48
Population Share, 2001 (%)	100	8.07	2.62	5.88	2.02	3.57	5.50	16.17	0.82
Decadal Growth rate during 1991-2001 (%)	21.34	**28.43**	23.19	24.34	18.06	15.94	28.33	25.80	19.20
Change in decadal growth rate (% points)	-2.52	**5.05**	-0.84	-2.90	-7.67	-4.12	-0.11	0.25	-0.03
Female literacy, 2001 (%)	54.28	**33.57**	39.38	50.28	52.40	50.97	44.34	**33.57**	60.60
Rise in female literacy since 1991 (% points)	**15.00**	11.58	**13.86**	**20.93**	**24.88**	**16.29**	**23.90**	**9.20**	**18.97**
Decadal decline in the number of illiterates (million)	**31.96**	**-2.98**	**0.07**	**3.65**	**2.07**	**1.92**	**3.66**	**4.50**	**0.47**
B: Estimates from Rapid Household Surveys (1998, 1999)									
Safe delivery (% of total deliveries)	41.9	**18.8**	19.9	29.5	22.4	32.9	33.5	21.9	22.3
Couple protection rate (%)	48.1	**23.4**	27.8	47.1	40.1	49.4	40.5	29.1	39.9
Children fully immunised (%)	53.3	**20.1**	30.8	47.3	59.1	57.4	36.9	44.5	62.8

2 THE EMPOWERED ACTION GROUP (EAG)

2.1 An Empowered Action Group (EAG) was set up by the Government of India in the Ministry of Health & Family Welfare. with Department of Family Welfare as the nodal department "to enhance performance, particularly in states with below average socio – demographic indices that need focussed attention"

2.2 In preparation for the First Business Session of the EAG, the Department of Family Welfare has painstakingly prepared a comprehensive data set in respect of the 261 districts constituting these 8 states. This compilation is being circulated.

3 ROLE OF THE EAG

3.1 The notification of the Empowered Action Group [EAG] coincides, somewhat, with the conclusion of the Ninth Five Year Plan (1997 – 2002). This provides the EAG with a unique opportunity to make a difference at the national level (and by extension, at the state and district levels as well within these 8 states). At this stage, the EAG will pursue the following course of action:

(a) Ensure some coordination and consistency across the member Departments already notified i.e. the Central Government Departments of Elementary Education, Women & Child Development, Rural Development, Health, Family Welfare and the Indian Systems of Medicine & Homeopathy, in their formulation of the 10th Five Year Plan Schemes inasmuch as these pertain to the multi – sectoral agenda for population stabilization, prior to these being forwarded to the Planning Commission.

(b) Once the Plan Schemes are in position, the EAG to periodically review, identify and address issues of coordination in implementation between the member departments at the central and state levels.

(c) Government of India already has a health sector reform programme, which seeks to bring about management change and enhanced capacities within the public sector. All the eight EAG States are participating in this health sector reform programme. The reform programme is assisted by a number of development partners, and preparatory steps have been initiated. The EAG will seek to facilitate the change process by:

- ensuring appropriate policy development at the Centre,
- provisioning for technical assistance to the member States,

- addressing issues of coordination between member states and departments, and
- deploying financial resources, as appropriate and feasible.

(d) The Empowered Action Group will meet during the inter – session period at least twice a year, first after the budget session of Parliament, during May – June, and then after the monsoon session during October – November.

4 ADDRESSING THE MEMBER STATE GOVERNMENTS & DEPARTMENTS OF THE GOVT. OF INDIA

4.1 In relation to the goals of the National Population Policy, 2000, the Empowered Action Group urges each constituent State Government and Central Ministry / Department to:

- Articulate a management plan for change for say, the next one year, **concentrating on the top five issues in the State / Department.**
- List the **outcomes** that should be manifest at the end of one year.
- Identify the **resource gaps** that might hamper the achievement of these outcomes.

4.2 On the basis of the above, each constituent State / Department of GOI may quickly indicate:

- The supportive policy changes that are needed at the Central level.
- The precise technical assistance required for both the process and the outcomes.
- The additional mobilization of resources sought.

5 GOVERNANCE ISSUES

5.1 Shortage of Resources is NOT the primary issue

5.1.1 A 'shortage of resources' is often advanced as a primary reason for poor performance. While it is true that Governments anywhere would never have enough for all that they want to do, this facile response pattern warrants deeper examination. For a moment, let us look at the single largest programme in the

area of population and reproductive health i.e. the World Bank assisted Reproductive & Child Health Programme. The fund releases to the EAG states read along with the reported expenditures indicates huge unspent funds and a somewhat lackadaisical record of compliance with agreed performance indicators.

Table-2

Funds Released to EAG States & Reported Expenditures under RCH Programme

(Rupees in crores)

Year		India	EAG States							
			Bihar	Jhar-khand	MP	Chhatis-garh	Orissa	Rajas-than	UP	Uttar-anchal
1997-98	Release		9.59		12.85		7.16	11.03	16.47	
	Exp.		1.05		3.30		1.95	1.51	3.96	
1998-99	Release		7.28		10.74		5.60	6.95	13.95	
	Exp.		2.87		6.11		1.75	1.50	2.37	
1999-2000	Release		11.79		17.62		10.23	12.06	38.44	
	Exp.		8.60		21.53		1.55	0.45	24.75	
2000-01	Release		25.35	0.37	33.40	3.14	13.52	23.09	45.26	2.08
	Exp.		.40	0.00	1.95	0.00	3.18	4.25	8.98	0.00
Total	Release		54.02	0.37	74.63	3.14	36.54	53.14	114.14	2.08
	Exp.		12.92	0.00	32.90	0.00	8.44	7.73	40.08	0.00
% utilisation			23.93	0.00	44.09	0.00	23.12	14.55	35.11	0.00

5.1.2 **It is possible that member states have some difficulties in utilizing the funds released. In this respect, we could begin by deliberating upon the following key management issues at a subsequent meet of the EAG:**

- **Funds released by the DoFW, GOI, are not promptly made available to the nodal state departments by their respective state finance departments. EAG wants to help by focusing on remedial management interventions to overcome this problem;**
- The Central Council of Health & Family Welfare had endorsed the formation of composite Health & Family Welfare Societies at state and district levels. Orissa has pursued this matter; however, no other EAG state appears to have taken appropriate action in this respect.
- The State's own non - Plan releases to the districts are known to be delayed significantly from time to time, resulting in a cumulative back-log of salaries owed to medical / para – medical personnel.
- Cash releases made for facilitating referral transport are often not utilized in these 8 states.

5.1.3 Collateral evidence suggests that non-performance is endemic and not confined to any sector. Lack of performance in the health and demographic area is invariably found to exist in conjunction with similar lack of performance in poverty alleviation, literacy and education, water supply and sanitation and several other fields. The key issue is therefore *management capacity,* rather than resources. It appears more important for the EAG to set its agenda in terms of improving management of existing investments first.

5.2 Decentralisation & Convergence : Key to Management Reform

5.2.1 The National Population Policy 2000 (NPP 2000) provides a road map for improving the quality of lives people lead essentially through a massive expansion in the outreach and coverage of services and supplies which, inter alia, will simultaneously:

- serve to bring about a reduction in numbers by lowering the total fertility rates, and
- promote the achievement of national socio - demographic goals.

5.2.2 The key strategic themes articulated for this purpose are:

- Decentralised planning & programme implementation;
- Convergence of service delivery at village levels;
- Public – Private Partnership; and
- Mainstreaming of Indian Systems of Medicine.

5.2.3 The 73rd and 74th Constitution Amendments have ushered in new opportunities consequent upon the implementation of political and administrative decentralisation. This has created the space for new institutional frameworks that have the mandate and the capacity to enable decentralised and inter – sectoral action for addressing tasks of basic health care, primary and elementary education, drinking water and sanitation, rural development, the ICDS programme, and so on. These new arrangements have the potential to revamp service delivery and bring about convergence between say, the Auxiliary Nurse Midwife (ANM) at the health subcentre and the Aanganwadi Worker in the ICDS programme, and in this manner, to facilitate community and inter – sectoral action on key development goals.

5.2.4 The impact of decentralisation to the Panchayati Raj Institutions (PRIs) and to diverse stakeholders including the voluntary sector, the non-government organisations and the private sector, is clearly visible in Kerala, whose socio-demographic indicators rival those achieved in the South-East Asian region.

Central and state departments, by reason of their fragmented functioning, are unlikely to achieve the convergence needed for implementing the inter –sectoral agenda adopted by Government in the National Population Policy, 2000. Decentralisation and the convergence are really two sides of the same coin.

5.2.5 The constituent central and state departments of the Empowered Action Group (EAG) could initiate and ensure convergence at several levels, example:

- Consistent priorities, objectives and time – frames.
- More formal inter – departmental collaboration on programme design, both at the state and at the central levels.
- Simplified, consistent reporting arrangements.
- Convergence of training for the frontline functionaries, starting with the village level workerswho have been placed under the PRIs. This will enable a team approaches in the field and at headquarters .
- Reduced duplication by common use of systems [for example, logistics and warehousing], staff and equipment.
- Joint Reviews and Workshops.
- Convergence of efforts at capacity building of the PRIs
- A convergence platform for pooling resources that are set aside for supporting the NGO activities (individual departments could continue to hold their corpus but support areas, selection criteria, financing systems, and monitoring arrangements could be made, subject to an agreed operational framework, supervised by the EAG).
- Convergence in the community needs assessment based planning among the member departments at state, district and sub-district levels.
- Improved utilisation of financial assistance.
- An appropriate horizontal convergence of key vertical programmes and programme strategies for maximum efficiency and effectiveness.
- Co-ordination with external development partners.

5.3 Community Needs Assessment Approach (CNAA)

5.3.1 Prior to 1996, the Department of Family Welfare followed a target driven approach. All planning and provisioning of services was geared to the achievement of demographic goals. Targets were evaluated in terms of a couple protection rate (CPR), which was further dis-aggregated into method specific targets, centrally administered, with particular emphasis on sterilization. This approach suffered from innumerable infirmities, not the least of which were

inflated figures of performance, complete neglect, to the point of omission, of quality of care provided to the people and disregard of the needs of the individual clients, besides coercion in the field to comply with diktats from above. This approach was fortunately replaced by a decentralized participatory approach with emphasis on client satisfaction, quality of services and citizens' choice under a Target Free Approach, renamed the Community Needs Assessment Approach (CNAA) in 1997-98. Moving away from targets was a major organizational change to be implemented through the vast central and state bureaucracies. The responses from some of the EAG states has been heartening. Rajasthan introduced a new innovative information and service delivery system in Dausa and Tonk districts. Uttar Pradesh carried out operations research in Agra (a high performance district) and in Sitapur (a low performance district). Additionally, Madhya Pradesh and Orissa are doing well now.

5.3.2 Under the CNAA, state governments are required to formulate District Action Plans (Form 4), derived from the felt and perceived needs of the community, and a State Action Plan (Form-5), and also compile the achievement (performance) statistics (Form-9) in respect of family planning and MCH services. The ANM is expected to undertake extensive house-to-house surveys in order to dialogue with households and update her data in respect of eligible couples and determine their felt and perceived needs. This statement of assessed needs is to be discussed with the local level functionaries like anganwadi workers, members of Mahila Swasthya Sanghs and during meetings of the gram panchayat. The District Action Plan should be discussed in the Zilla Parishad before it is finalized. The Community Needs Assessment Approach is essentially a tool for eliciting public participation and involvement in the design and formulation of the Annual Action Plan.

5.3.3 However, the sense of urgency and enthusiasm generated by Government of India, Department of Family Welfare towards operationalising the CNAA has not always been matched by response patterns within the state governments. They have not developed ownership for the community needs assessment approach, nor do they utilise it as a critical tool for decentralizing the planning process. This is evident from the figures in Table 3 below (please see next page) .

5.3.4 Member states may like to share with the EAG any difficulties they are experiencing in operationalising the CNAA..

Table 3: Receipt position of CNAA based District Action Plans

State	1999-00	2000-01	2001-02
Bihar	3 / 55	2/ 37	2 / 37
Jharkhand	2 / 18	1 /18	
Madhya Pradesh	16 / 61	38 /46	
Chhattisgarh	8 /16	12 / 16	
Orissa	21 /30	23 /30	10 /30
Uttar Pradesh	61 / 85	58 / 72	4 / 72
Uttaranchal	5 / 13	9 / 13	
Rajasthan	32	30 / 32	

5.4 Public – Private Partnership

5.4.1 A national effort to reach out to households cannot be sustained by government alone. We need to put in place, and sustain a partnership of the non – government organisations, the private corporate sector, government and the community. Where government interventions or capacities are insufficient, and the participation of the private sector unviable, focussed service delivery by NGOs may effectively complement government efforts.

5.4.2 The predominantly dysfunctional **primary health care infra - structure** manifests in the reduced share of utilisation by the poorest segments of the population. There exists country –wide, a vast and widely dispersed network of rural health infra - structure, comprising :

- 1.37 lakh health sub - centres,
- 25, 000 primary health centres,
- 4,000 community health centres
- 25, 000 ISM dispensaries.

5.4.3 However, these channels are somehow neither adequately managed by the public sector, nor generally available to non-government organisations / or others, who might run these as low cost facilities with a basic package of health services for men women and children, dispensed reliably and regularly. States that have contracted out the management and administration of their primary health care infra-structure example, Tamilnadu, Karnataka, Gujerat and Maharashtra have succeeded in provisioning for basic and essential clinical and

non-clinical services at the sub - centres and primary health centres, extended outreach and successfully focussed on **quality of care.**

5.4.4 Then there is the problem of **supplies**. It is often the case that even the products meant for free disbursal are not found in the government rural health care facilities. There is a case for enabling both free as well as socially marketed health products (not restricted to the subsidised products only), appropriate access in sub-centres, primary health centres and community health centres, as well as in satellite clinics and dispensaries. This will immediately and simultaneously promote visibility, availability, and acceptability of these products. Besides, it will address the unmet need for health care products and services, and serve to expand the market. Modalities for facilitating these arrangements to promote wider access, outreach and coverage would need to be worked out.

5.4.5 Additional channels like the ICDS programme, the community based distribution (CBDs) groups, and the self – help groups (SHGs) could similarly be utilised for the dissemination and promotion of concepts, ideas, products and services in respect of health, nutrition, basic literacy and primary / elementary education, as well as for skill upgradation and income generating activities, to access the vast numbers in the under - served segments of the population, primarily in the rural areas and the urban slums. It has been demonstrated that face to face or small group interactions with health providers / educators / peers have sometimes been more effective than mass media campaigns at changing behavior.

5.4.6 The mal-distribution of doctors, besides trained and skilled manpower in the health sector is well documented. At the national level, the number of doctors at the primary health centres exceeds the requirements, as per the norms. However, in the rural areas, and particularly, in the more inaccessible and remote areas, where there is virtually no provisioning by the voluntary and non-government sectors, the primary health centres are without doctors or para – medical personnel. State governments are resorting to innovative strategies to fill in the vacancies and operationalise the health facilities: appointment of doctors on contract, enabling the private corporate sector or charitable organisations, or cooperatives and self –help groups (SHGs) to adopt a primary health centre, permitting local practitioners to examine patients in the primary health centres during the prescribed OPD hours, and to thereafter conduct private practice. The member state governments should suggest additional modalities for improving the dispersal of doctors, besides skilled and trained manpower within their primary health infra-structure, for enhancing quality of care.

6. REDUCING MATERNAL MORTALITY

6.1 High MMR is a matter of constant concern in these eight states covered by the EAG, as indicated in Table 4 below:

Table 4 : Maternal Mortality Rates in EAG States
(Number of maternal deaths per 100,000 live births)

Bihar	MP	Rajasthan	UP	Orissa
451	498	607	707	739

6.2 Given its mandate, the EAG calls upon the States to articulate (besides other sectors), their H & FW sector reform agendas and the expected outcomes for the short term, say for the first year. These do not have to be overly ambitious. The maternal mortality rate in most of India and certainly in the eight States represented, for example, is among the worst in the world. Estimates indicate that one woman dies every six minutes in India from causes related to pregnancy and childbirth. It has long been known that the relatively simple intervention of having medical facilities that offer functional first referral services, reliably and round the clock, can save the lives of innumerable women.

6.2 However, the number of functioning FRUs continues to be abysmally low and insufficient to have any impact on the MMR. The EAG would like a resolution made, in its first meeting, that *at least* one functional facility offering obstetric first referral services will be available in every district of the eight States represented here, by the end of 2002 - 2003. These facilities will be verifiable by external inspection.

7 ADVERSE SEX RATIO

7.1 Advances in medical technology facilitate pre-natal sex identification, and make sex – selective abortion feasible. The well established preference for male progeny combined with an emerging preference for small families is perhaps resulting in a loss of girls either before or at birth, and even immediately / soon after birth on account of female foeticide, son preference, discrimination against the girl child and neglect, leading to lower allocations of nutrition and health care within households.

7.2 Census 2001 estimates indicate that the overall sex ratio has improved in all EAG States since the last census which has contributed to the overall increase at the national level. What is worrying, however, is that the sex ratio for the 0-6 year

age group has declined in all EAG States (Table-5, In some cases, the decline is alarming.

Table-5: Sex ratio in the EAG States and India

State /India	Overall sex ratio (number of females per 1000 males)			Sex –ratio for 0-6 year age group		
	1991	2001	difference	1991	2001	Difference
India	**927**	**933**	**6**	**945**	**927**	**-18**
Bihar	907	921	14	953	938	-15
Jharkhand	922	941	19	979	966	-13
MP	912	920	8	941	929	-12
Chhatisgarh	985	990	5	984	975	-9
Orissa	971	972	1	967	950	-17
Rajasthan	910	922	12	916	909	-7
UP	876	898	22	927	916	-11
Uttaranchal	936	964	28	948	906	-42

7.3 The Pre-Natal Diagnostic (Prevention and Misuse) Act has been implemented since January 1996. The legal framework for enforcing prevention and misuse of the Act is in place. However, the Hon'ble Supreme Court of India have most recently commented adversely on virtual non-implementation of this Act. All appropriate authorities at the State and district levels have been directed to furnish quarterly returns on the implementation and working of the PNDT Act, with specific information in respect of survey and registration of bodies enumerated in the Act, action taken in respect of violation of the Act, inclusive of search and seizure of records, and, finally, the number and nature of awareness campaigns conducted. The medical and professional bodies and associations in the State are to create awareness amongst the public and among their members against the practice of pre-natal determination of sex and female foeticide.

7.4 It is imperative that the EAG States adhere to the directions of the hon'ble Supreme Court and improve their sex ratio.

AGENDA NOTES

CONTRIBUTED

BY

DEPARTMENT OF ISM & H

FOR EMPOWERED ACTION GROUP MEETING ON 18.6.2001

AGENDA NOTE:

MAINSTREAMING OF ISM IN STATES OF BIHAR(INCLUDING JHARKHAND), MADHYA PRADESH(INCLUDING CHHATISGARH) RAJASTHAN, UTTAR PRADESH (INCLUDING UTTRANCHAL) AND ORISSA.

For decades now practitioners of ISM have been contributing in public health care activities. After independence GOI and the States made several efforts to streamline these systems. It has been the policy of Govt. to develop each of these systems according to their genius and integrate the best of all their services at health care delivery level. To achieve these goals a huge infrastructure has been created including the constitution of research councils and formation of Central Councils for Indian Medicine and Homoeopathy to regulate standards of education and the registration of practitioners. There is a uniform course of 5-1/2 years after 10+2 Science Stream. The syllabus of these courses has been designed in such a way that the student while getting a good knowledge in the Indian system is also exposed to necessary modern advances, so that he/she can attend to a patient's needs at a general (not specialised) level.

The research councils in ISM&H have also done a lot of research work which has led to the patenting of drugs for Malaria, Epilepsy, Psoriasis, etc.

There is a strong base for ISM in rural India. The situation in rural areas is not suitable by and large for modern medical practice, since well equipped laboratories and sophisticated diagnostic tools which are required for diagnosis and treatment are not available. Generally, modern medicine doctors are unwilling to serve in rural PHCs and thus many gaps have been left in meeting the objectives and strategies of the RCH Programmes. There are many antenatal, intra-natal and post-natal procedures described in ayurveda that could be adopted with success in rural villages.

Â sample survey was conducted by CCRAS in July 2000 covering 13 States through a questionnaire involving 92 centres both governmental and private where data covering 103 physicians of ISM&H and 2.16 lakh of patients seen by them in a month were examined. It was seen that practitioners of ISM&H have already been effectively treating various gynaecological, antenatal, postnatal, neonatal and paediatric problems by using drugs of their own systems in 68-70% of cases. In the remaining cases where required modern medicine was administered by these practitioners. The Summary of this survey may be seen at **Annexure I**.

Supreme Court in their judgement in 1998 in Civil Appeal No.89 of 1987 in respect of Dr. Mukhtiar Chand & Others Vs. State of Punjab and Others observed that prescribing and practising are not distinct entities and that a person who is entitled to prescribe can practice and vice-versa. Thus the Honourable Court while upholding the provisions and rules in this context clearly mentioned that if any State Government had declared anyone as person practising modern medicine under Drug Rule 2(ee) iii, such person can prescribe modern medicine and practise as well. The Honourable Court also observed that if there are any separate State Acts enabling persons to practice in modern medicine, they may also do so. The operative part of the judgement may be seen at **Annexure II.**

Thus, in states where certain ISM practitioners have been allowed to practice modern medicine, their services can be utilised in National RCH programme by giving a little reorientation training in modern approaches. In addition all institutionally trained practitioners may utilise the approaches of their own systems in RCH practices. Â minor group of non-institutionally trained practitioners may by appropriate training help in IEC programme in motivating and spreading the message and in distribution of condoms, pills, etc.

The ISM infrastructure in States like Bihar (including Jharkhand), Madhya Pradesh (including Chhattisgarh), Rajasthan, Uttar Pradesh (including Uttaranchal) and Orissa is given in the **Annexure III.** In the State of Bihar and Rajasthan there is no provision for ISM practitioners to practice modern medicine. In other States of Madhya Pradesh, Uttar Pradesh (including Uttranchal) and Orissa certain groups of ISM practitioners were allowed to use modern medicine. The Status in Various States is at **Annexure IV.**

These States may identify districts where there are gaps in the availability of modern practitioners and the Govemmental or Zilla Panchayat ISM dispensaries available in these districts may be treated like a PHC for extending the National RCH programme after giving reorientation training to the ISM practitioners where required.

The following action is required to be taken :

1. Identify the gaps that exist in respect of availability of medical manpower in PHCs/CHCs and also identify the ISM dispensaries where RCH programme can be implemented.
2. Identify the group of ISM practitioners who need to be given training.
3. Organise training for identified group of ISM practitioners in the use of their own drugs & methods and in the use of modern RCH programmes/drugs at selected ISM colleges and Modern Hospitals. The training may be for a period of 1 week in ISM colleges and for a period of 2 weeks in Modern Hospitals.
4. To equip the identified ISM dispensaries for undertaking the RCH programme and to post the ISM doctor in the PHCs/dispensaries.
5. Providing necessary medicines (both ISM drugs and modern drugs) and condoms, copper T, etc., in the identified PHCs and ISM dispensaries.
6. To give targets and set up a monitoring system.

Annexure I

A REPORT ON RANDOM SURVEY ON THE ASSESSMENT OF SERVICES RENDERED BY ISM & H DOCTORS IN THE AREA OF REPRODUCTIVE CHILD HEALTH (RCH)

SUMMARY

A random sample survey conducted in July 2000 in 13 States through a questionnaire covering 92 centres of both governmental and private institutions involving 103 physicians of ISM&H and 2.16 lakh of patients in a month indicate that practitioners of ISM&H have already been effectively treating various gynaecological, antenatal, postnatal, neonatal and paediatric problems by using drugs of their own systems in 68- 70% of cases. In the remaining cases where required modern medicine was administered by these practitioners .

The study also shows that these practitioners have also been engaged in conducting normal deliveries and adopting few surgical procedures like MTP, Episiotomy, forceps application, and removal of retained placenta.

The study further reveals that these ISM&H practitioners are very much involved in advocating oral contraceptives, IUCD insertions and in performing to a lesser extent operations like vasectomy and tubectomy, etc.

Status of RCH Practices rendered in ISM&H Dispensaries/Hospitals.

Institutions studied :	Governmental:	65	
	Private	27	
	Total	**92**	
	Ayurveda	75	
	Siddha	13	
	Unani	3	
	Homoeo	1	
	Total	**92**	

Institutional Break-up:	Dispensaries	13	
	Research centres	30	
	Colleges	15	
	PHCs	7	
	Private Clinics		18
	Hospitals	9	
	Total	**92**	

Physicians Involved :

	Medical Officers	Research Officers	Teachers	Private Practitioners	Total
Ayurveda	40	2	18	23	83
Siddha	4	2	2	5	13
Unani	4		1	1	6
Homoeo	1				1
			Total		103

States Studied

1.	Himachal Pradesh	Mandi – Paprola
2.	Tamil Nadu	Chennai
3.	Orissa	Puri, Bhuwaneshwar
4.	Kerala	Trivendrum, Prashar
5.	Bihar	Patna
6.	Uttar Pradesh	Hastinapur, Lucknow
7.	West Bengal	Calcutta
8.	Pondicherry	
9.	Jammu	
10.	Punjab	Patiala
11.	Rajasthan	Jaipur : Udaipur
12.	Maharashtra	Mumbai, Nagpur
13.	Karnataka	Bangalore

Total Patients Studied : 2,15,745

Diseases treated by:

	Indian Medicine	Modern Medicine	Total
Gynaecological problems			
1.Dysfunctional uterine bleeding	2087	271	2358

	Indian Medicine	Modern medicine	Total
2.Dysmenorrhoea	2024	296	2320
3.Backache	2820	291	3111
4.Reproductive tract infection	3096	522	3618
5.Infertility	986	66	1052
6.Piles & fistulae	1262	158	1420
Antenatal problems			
1.Morning sickness	1127	245	1372
2.Anaemia	2331	763	3094
3.Edema feet	1169	361	1530
4.Hypertension	756	471	1227
5.Albumin urea	395	247	642
6.Immunisation		1101	1101
Postnatal problems			
1.Infections	689	894	1583
2.Post partum haemarrhage	423	108	531
3.Fluid supplements / blood transfusions		222	222
4.Physiotherapy/massage	1540	70	1610
5.Use of Galacta gogues	1188	55	1243
Neonatal problems			
1.Conjunctivitis	712	174	886
2.Excess crying	694	119	813
3.Jaundice	520	28	548
4.Rigors/convulsions	52	24	76
5.Supplemental milk advocated	522	143	665

	Indian Medicine	Modern Medicine	Total
(animal/powder)			
6.Immunisation schedule adopted		615	615
Paediatric problems			
1.Diarrhoea	2144	567	2711
2.URT infections	2215	420	2635
3.Viral fevers	1502	499	2001
4.Intestinal worms	1728	212	1940
5.Pica (soil eating)	1100	132	1232
6.Noeturnal enuresis	733	78	811
Surgical interventions			
1.MTP		285	285
2.Episiotomy		40	40
3.Foreceps delivery		7	7
4.Caesarean sections		3	3
5.retained placenta		7	7
6.D&C operation		10	10
Contraceptive procedures adopted			
1.Oral	100	1022	1122
2.IUCD applications		380	380
3.Vasectomy done		21	21
4.Tubectomy done		49	49

OPERATIVE PART OF THE SUPREME COURT JUDGEMENT

CIVIL APPEAL NO. 89 of 1987

Dr. Mukhtiar Chand & others VS State of Punjab & others

dt 13-9-98

II

The upshot of the above discussion is that Rule 2(ee) (iii) as effected from May 14,1960 is valid and does not suffer from the vice of want of the legislative competence and the notifications issued by the StateGovernment there under are not ultra vires the said rule and are legal. However, after sub-section(2) in section 15 of the 1956 Act occupied the field vide Central Act 24 of 1964 with effect from June 16,1964 the benefit of the said rule and the notifications issued thereunder would be available only in those states where the privilege of such right to practise any system of medicine is conferred by the State Law under which practitioners of Indian Medicines are registered in the State. Which is for the time being in force. The position with regard to Medical practitioners of Indian medicine holding degree in integrated courses in on the same plain in asmuch as if any State Act recognizes their qualification as sufficient for registration in the State Medical Register, the prohibition contained in Section 15(2)(b) of the 1956 Act will not apply.

In the result, civil appeals special leave practitioners and writ petitions are accordingly disposed of.

There shall be no order as to costs.

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(K.T thomas)

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(Syed Shah Mohammed Quadri)

ANNEXURE III

ISM&H DISPENSARIES AVAILABLE IN THE STATES OF BIHAR(INCLUDING JHARKHAND), MADHYA PRADESH(INCLUDING CHHATISGARH) RAJASTHAN, UTTAR PRADESH (INCLUDING UTTRANCHAL) AND ORISSA.

States	Dispensaries as on 1.4.1998								
	Ayurveda			*Unani*			*Homoeopathy*		
	Govt.	Non-Govt.	Total	Govt.	Non-Govt.	Total	Govt.	Non-Govt.	Total
Bihar (including Jharkand)	216	306	522	86	42	128	118	63	181
Madhya Pradesh (including Chhatisgarh)	2074	19	2093	55	0	55	201	0	201
Rajasthan	3433	36	3469	77	0	77	111	5	116
Utter Pradesh (including Uttranchal)	386	327	713	71	77	148	1328	0	1328
Orrisa	519	5	524	9	0	9	460	43	503

DETAILS OF BED STRENGTH IN ISM HOSPITALS IN THE STATES OF BIHAR(INCLUDING JHARKHAND), MADHYA PRADESH(INCLUDING CHHATISGARH) RAJASTHAN, UTTAR PRADESH (INCLUDING UTTRANCHAL) AND ORISSA.

States	Hospital with bed strength in bracket								
	Ayurveda			*Unani*			*Homoeopathy*		
	Govt.	Non-Govt.	Total	Govt.	Non-Govt.	Total	Govt.	Non-Govt.	Total
Bihar (including Jharkand)	4(236)	5(635)	9(871)	1(24)	3(390)	4(414)	1(100)	0	1(100)
Madhya Pradesh (including Chhatisgarh)	34 (1160)	0	34 (1160)	0	1 (60)	1 (60)	4 (140)	8 (450)	12 (590)
Rajasthan	78 (784)	12 (395)	90 (1179)	3 (30)	2 (240)	5 (270)	2 (10)	3 (150)	5 (160)
Utter Pradesh (including Uttranchal)	1594 (9421)	77 (490)	1671 (9911)	131 (726)	5 (460)	136 (1186)	36 (399)	0	36 (299)
Orrisa	5 (203)	2 (110)	7 (313)	-	-	-	4 (125)	1 (125)	5 (125)

AVAILABILITY OF MANPOWER(REGISTERED PRACTITIONERS)IN THE STATES OF BIHAR (INCLUDING JHARKHAND), MADHYA PRADESH(INCLUDING CHHATISGARH) RAJASTHAN, UTTAR PRADESH (INCLUDING UTTRANCHAL) AND ORISSA.

States	Manpower (RMP)								
	Ayurveda			*Unani*			*Homoeopathy*		
	Institutional	Non-institutional.	Total	Institutional	Non-institutional	Total	Institutional.	Non-institutional	Total
Bihar (including Jharkand)	75711	0	75711	3250	0	3250	11644	14025	25669
Madhya Pradesh (including Chhatisgarh)	45834	1296	47130	326	101	427	5689	1105	6794
Rajasthan	23089	2967	26056	1432	0	1432	1563	2387	3950
Utter Pradesh (including Uttranchal)	38759	17162	55921	7043	4920	11963	11460	13251	24711
Orrisa	2474	1179	3653	15	0	15	2599	2134	4733

EXISTENCE OF LEGISLATION PERMITTING ISM DOCTORS TO PRACTICE MODERN MEDICINE.

States	Provision for modern medical practice by ISM Graduates.
Bihar (including Jharkand)	No Provision
Madhya Pradesh (including Chhatisgarh)	Notified certain categories to practice allopathy.
Rajasthan	No provision.
Utter Pradesh (including Uttranchal)	Notified certain categories to practice allopathy.
Orrisa	Notified certain categories to practice allopathy.

Present status of Practice of Modern Medicine by Ayurvedic practitioners in different States.

States with separate Acts enabling Practitioners of Indian Medicine to practice in Modern Medicine.

Sl.No.	Name of the State	Act
1.	Tamil Nadu	Madras Registration of Practitioners of Integrated Medicine Act, 1956
2.	Karnataka	The Mysore Ayurvedic and Unani Practitioners Registration and Medical Practitioners Miscellaneous Provisions Act, 1961.
3.	Kerala	The Travancore-Cochin Medical Practitioners Act, 1953
4.	Maharashtra	The Maharashtra Practitioners Act, 1961.
5.	Gujarat	The Gujarat Medical Practitioners Act, 1963.

States who by special notifications have authorised certain categories of ISM practitioners to practice in Modern Medicine.

1. Andhra Pradesh
2. Punjab
3. Haryana
4. Delhi
5. Uttar Pradesh
6. Jammu & Kashmir
7. Himachal Pradesh
8. Madhya Pradesh
9. Orissa.

States who provided a saving clause for certain categories of ISM practitioners under their State Medical Council Acts stating that if such persons are found practising modern medicine they are not punishable under the provisions of the said State Medical Council Act.

1. Madhya Pradesh
2. Delhi

With no provision for practice of modern medicine for ISM practitioners.

1. Assam
2. Bihar
3. West Bengal
4. Rajasthan

Section 3

Text of the address by

Secretary (FW)

First Business Session of the EAG

Text of the address by Mr. A. R. Nanda, Secretary (FW)

1. The Hon'ble Prime Minister in his inaugural speech in the meeting of National Commission on Population on 22.7.2000 had announced that in order to facilitate the attainment of goals as enumerated in National Population Policy, the Government would set up an Empowered Action Group (EAG) attached to the Ministry of Health. The Group will be charged with the responsibility of preparing area-specific programmes with special emphasis on States that have been lagging behind in containing population growth to manageable limits and will account for nearly half the country's population in the next two decades.

2. The Group will also concentrate on involving voluntary associations, community organisations and Panchayati Raj Institutions in this national effort. It will explore the possibility of expanding the scope of 'social marketing' of contraceptives in a manner that makes them easily accessible even while raising awareness levels.

3. As mentioned by the Hon'ble Prime Minister, the Group will endeavour to achieve the following:

- Universal access to quality family planning services so that the small-family norm becomes a reality
- Total coverage of registration of births, deaths and marriages
- Full access to information on birth limitation methods and freedom of choice, especially to women, for planning their families
- Reduction of Infant Mortality Rate to below 30 per thousand live births, incidence of low birth weight and maternal mortality rate
- Immunization against vaccine preventable diseases
- Elimination of incidence of girls being married below the age of 18
- Increase in the percentage of deliveries conducted by trained persons to 100 per cent
- Contain Sexually Transmitted Diseases, especially AIDS
- Universalisation of 'primary' education and reduction in the dropout rates at primary and secondary levels to below 20 per cent for boys and girls.

4. The EAG seeks to pay attention on areas which are lagging behind in containing population growth with particular emphasis on eight States of Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh, Orissa, Chattisgarh, Jharkhand and Uttaranchal which contributes, at present, about 45% of the population of the country.

5. The **Terms of Reference** of the Empowered Action Group(EAG) have been notified on 20th March, 2001. The thrust areas will be :

(i) To formulate programmes aimed at achieving the socio-demographic goals enumerated in National Population Policy 2000.

(ii) To introduce information technologies and management information systems, at district and sub-district levels, to monitor availability and access to contraceptives, drugs and vaccines, as well as to services, in the near and far flung areas.

(iii) To improve the existing systems for logistics.

(iv) To implement the paradigm shift in the management of programmes for population stabilization by incorporating diverse health care providers.

- Accrediting private medical practitioners and assigning to them defined satellite populations for whom they will provide basic health services;
- Reviving the system of licensed medical practitioner; who can provide specific clinical services, after appropriate certification;
- Involving the non-medical fraternity;
- Creating a network in these states of all manner of health facilities, identified by a common logo, to provide reproductive and child health services free to any client;
- Forming a consortium of the voluntary sector, the non-government sector and the private corporate sector to aid government in the provision and outreach of basic reproductive and child health care and basic education;

- Mainstreaming Indian Systems of Medicine;
- To position appropriate health care providers at every CHC/PHC/Sub-Centers in these states, to target 24 hour service delivery at the primary health centers in these states;
- To pilot convergence of service delivery at village levels, through self help groups, with the help of the voluntary sector and the non-government organisations ;
- To finalise a targeted campaign for information, education and communication in these states that will involve the community, civil society, opinion leaders and political representatives, from village levels upwards, for dissemination of advocacy, information and communication ;
- To energize the existing systems of referral transportation, training of dais, and quality of reproductive health care through a public private partnership;
- To put in place intensive monitoring systems, inclusive of concurrent evaluations and reliable, detailed household and facility surveys, through professional agencies;
- To ensure implementation of district planning through the community needs assessment reporting from each of the districts;
- To align program and project delivery with advances in current technologies in reproductive research;
- To pioneer projects for extending wider coverage and outreach of basic health care services through the active participation of non-government organisations, the voluntary sector and the private corporate sector, particularly in the area of referral transportation and improving quality of care;
- To explore the possibility of expanding the scope of social marketing of contraceptives in a manner that makes them easily accessible even while raising awareness levels;

6. In order to have an analysis of the present situation to facilitate decision about formulation of future programmes, a detailed compilation of the demographic data as

available from Census-2001, NFHS-I, NFHS-II, District Rapid Household Survey, SRS and data available with the Women & Child Development has been compiled by Department of Family Welfare which gives details in respect of crucial indicators, flow of funds, area projects, ranking of districts according to various indicators, maps and areas of concern for each State has been provided to you. Another compilation for each of the 261 districts within these EAG States is also being prepared which will serve as a handy tool for the task of preparing area specific projects.

7. The EAG has to strive to deliver results in a definite time-span. The EAG has a tough task ahead. It may be noted that the first meeting of the EAG has been designated as "First Business Session". This is with the intent of reinforcing the mission mode in which the issue has to be addressed.

8. Although the Agenda of the deliberations has been circulated, however it is really up to the members of the EAG to discuss and decide on the future course of action to be adopted by the EAG which will be most crucial in yielding results. We may decide upon the key interventions over a definite time frame which need to be addressed. To my mind, one of the areas of utmost importance would be not only provisioning of funds and supplies but also the willingness of the State Governments to work in tune with the Government of India. The past experiences for the area projects and even the RCH programme show that despite availability of funds and flexibility in procedures there is still the problem of vacancies, lack of maintenance and neglect for infrastructure and non-sensitization of staff. We need to use the offices of our Regional Directors in a more systematic manner and ensure their coordination at the State level for best results.

9. In course of discussions it is also to be decided how the available resources of Rs.30 crores within the domestic budget for the EAG States are to be utilized in the current financial year. It is suggested that this should be linked to performance of Districts/States in respect of key indicators.

10. It is also proposed that each State and Government Department may identify five / six core issues on which it will focus for reform and results in the current financial year.

11. Although we plan to have six-monthly meetings for the EAG but it may be necessary to have one meeting in every eight weeks at the level of the Department of Family Welfare to sustain the momentum of the programme.

12. We may also consider how the experiences of States like Kerala, Tamil Nadu, Karnataka, Andhra Pradesh, and Maharashtra, etc., which have yielded impressive results can be utilized for improvement of systems in the EAG States.

Section 4

Text of the speech by

Health & FW Minister (HFM)

Speech of Hon'ble HFM and Chairman, EAG at the First Business Session of the Empowered Action Group

It is nearly fifty years since the country launched the first ever National programme of Family Planning, India is still struggling to stabilize its population growth. The country has the dubious distinction of welcoming its one-billionth child in the new millennium. The recent census figures have brought out the immediate need for revamping and strengthening of the Family Welfare programme in some states. It is for this purpose, that the Empowered Action Group (EAG) was constituted to look into the problems of area-specific needs of states with special emphasis on 8 states that are lagging behind in bringing population growth to manageable levels.

Today we are here to address the problems of these 8 states, which are likely to account for 55% of the projected increase in population over the next 45 years. This has thrown open newer challenges of ensuring political commitment, sectoral reform, systemic innovations, and of building partnerships with civil society for provisioning basic health care to the people in the villages, slums, tribal and hilly areas.

Though the country spends billions of rupees every year on social sector, there has been a plateauing of the measures of health and well being for many years, especially in the EAG States. It is time to let the people and communities of India to get involved at all levels for priority setting and decision-making.

However, I need to issue a word of caution for those who are trying to grapple with the problem with a shortsighted vision and advocating imposition of two-child norm or introducing incentives and disincentives in State Population Policy to achieve the goal of population stabilization. Though two children or less is ideal India being a signatory to the ICPD Declaration at Cairo coercive methods have no role in

stabilizing population growth. Instead improvement in provisioning of basic health care services would lead automatically to improvement in living standards and will facilitate the people to make right choices and decisions regarding family size they need to have. Deviation from this path has been tried before with damages that still scar the memory of the people and have proved a deterrent to the success of the programme for almost 20 years after. There is no way to achieve population stabilization other than by improving the status of woman in the society - by empowering her, by making her more literate, well informed, healthy, employed and a responsible member of the society. The EAG, therefore strives to achieve this synergization of efforts across the sectors of elementary education, rural development, Indian systems of medicine and health.

There is also the need to accept that even in the States where the programme for family welfare has been a success it has really been a result of partnerships built among the civil society, the political leadership and the administrative structure. Looking to the vast needs of India and the remote underserved pockets, we have to look at alternate modalities for providing services to people rather than on insisting on increasing the already mammoth structure of the Government. We need cooperation and commitment from voluntary sector, Panchayati Raj Institutions, media, pressure groups and private practitioners, who will have to provide the platform on which these services can be provided to the people. This is not an easy task. Herein lies the challenge to the EAG. Much is expected of it. Much will be demanded of it. Much depends on it being able to rise to the challenge.

Interestingly, the problem in the EAG States is not of population stabilization alone, rather it is a quagmire of poverty, illiteracy and poor management. The problems of inverse sex ratio, plateauing Infant Mortality Rate, disturbing trends of maternal mortality, low literacy levels, all contribute to a situation where emancipation and development take a backseat. I appreciate that the First meeting

of the EAG has been designated as the First Business Session. This, in some measure should indicate the business like approach, which we need to adopt in tackling these issues. It is also important for us to arrive at a consensus about the timeframe in which the EAG will deliver its mandate. At the end of the day we should be clear on what type of support and results that can be expected from the EAG by the States and what can be the results that can be expected by the people of India from the EAG.

It needs no clarification that availability of funds is not the issue while addressing the challenges in the EAG States. Rather, we find that **many of these states have spent less than 50% of the available funds**. So instead of complaining about scarcity of resources, we need to ensure that the gaps in infrastructure, manpower, availability of contraceptives and services will have to be addressed in a systematic manner. On this occasion **I declare that EAG will ensure 100% availability of condoms for the next three years**. But I appeal to the state governments to ensure availability of doctors and paramedics at least in the First Referral Units. Here I would like to draw your attention to a **major anomaly in the administrative set up at state level where majority of the employees involved in family welfare programme are in fact under the control of Health Department**. On many occasions this arrangement has put breaks and checks on the functioning of officials. Hence it is desirable to have the **control of health functionaries' up to the district level be transferred from Department of Health to the Department of Family Welfare in all States.** This is of utmost importance to ensure effective execution and monitoring. Added to this is the necessity and desirability of involving the Panchayati Raj Institutions in planning/supervising the health infrastructure in the rural areas as in many states this is the responsibility of Panchayat bodies. The Ministry of Health & Family Welfare also has in place an advanced system of

computer network for monitoring programmes like leprosy, T.B. etc. If this is properly utilized we can have a better system of monitoring and supervision.

An important area of unmet needs relates to the gap in dissemination of information on government schemes. Not only the people but also the members of Panchayati Raj Institutions, health functionaries and bureaucrats needs to be apprised of these schemes. This information gap has to be closed so that the beneficiaries and providers of service become aware of innovative schemes like referral transport, RCH camps and Dai trainings. For example, the response to Health Melas organized by the Ministry of Health & Family Welfare has been tremendous in terms of family planning services/surgeries performed. **The Health Melas have indicated the level of unmet needs and also how the concept of integrated service delivery can make the difference.** Here I also wish to make an observation that even among the EAG States we should perhaps concentrate more acutely on the States of U.P. and Bihar. There is a need for joint monitoring at district level and also for creation of district SCOVAs for efficient routing of government funds and subsequent utilization of the same. With these words, I welcome you all to this meeting with a hope that at the end of the day we will all go with renewed enthusiasm and energy to accomplish the policy goals.

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Section 5

Announcements made by

HFM

Announcements made by Union Health & Family Welfare Minister in the press conference of First Business Session of the Empowered Action Group (EAG)

The GoI is committed to undertake all measures required to improve the quality of lives of people in the EAG states. The state governments have responded well to our initiatives. The EAG will provide the forum for better integration of efforts and is looking for putting in place a paradigm shift without delay.

More specifically, I propose the following:

1. The EAG states should quickiy explore **more innovative ways of managing rural health facilities,** maybe with the help of the private sector and / or the non – government sector, as has been tried with remarkable success in Tamilnadu and Karnataka. I take the opportunity to congratulate Madhya Pradesh and Rajasthan for the innumerable innovative steps taken for both decentralization and community participation.

2. The very first of the national socio-demographic goals for 2010, articulated in the National Population Policy, 2000 is to " address the unmet needs for basic reproductive and child health services, supplies and infra –structure" . In the EAG states we now require to greatly expand the provisioning of the package of health services, inclusive of family planning through the government health infra-structure to the **block levels**. This will require the creation of additional physical facilities, provisioning of additional equipment, trained health care providers, and mobility. We expect that the following services are being already provided, through the existing primary and secondary health infrastructure i.e. the ante-natal, natal [conducting deliveries] and post natal services. However, in actual practice, even though there are facilities [labour room and operating theatres] at the primary health centers and at the community health centers, there are reports of these being utilized less and less by the common man. Similarly for management of emergency obstetric cases, number of functional FRUs are low and insufficient. Al least all the district and sub-divisional hospitals should be made as fully operational FRUs for taking care of

emergency obstetric care. The linkages between the primary and secondary health care system need to be strengthened. The EAG states should identify precisely the package of assistance required, and the time frame within which these facilities can become operational, inclusive of a phasing in the utilization of resources. We have made a beginning. We have already enabled states to engage specialists and trained health care providers on contract. However, the performance of the EAG States has been less than satisfactory. They will need to look into other alternatives for providing trained manpower in rural health facilities, like trained paramedics and nurses and ISM practitioners. It is a question of organizing the provisioning and scheduling the activities in order to address the unmet need. Therefore, we should aspire to include facilities for manual vacuum aspiration, tubectomies, no –scalpel vasectomies, and medical termination of pregnancy at the block level primary health care facilities. The EAG will provide the necessary support for revamping equipment and tool –kits.

3. Turning to the urban areas, I propose that in the **post partum centers in the EAG states, at the subdistrict levels [436 in the EAG states]** must provide referral services and support to the block level facilities. Here the states bear a major responsibility. As I see it , there are two options : (i) either State governments fill up quickly the existing vacancies in the post - partum centers at sub – district levels (50% in UP, 48% in MP, 41% in Rajasthan, 32% in Bihar), or (ii) let us proceed to create maternity centers at sub-district levels in the existing post - partum centers. Limited services for maternal and child health are being provided at the existing post partum centers at sub – district levels . What I am proposing is an expansion in the scope of services that should become available at the sub –district levels. I invite the EAG states to identify the respective incremental requirements. We are open to consider all workable options. Innovations that can make the system work and deliver are welcome.

4. The National Population Policy, 2000 articulates the achievement of universal access to inforrnation / counseling and services for fertility regulation and contraception with a wide basket of choices, as a socio – demographic goal. If we pursue converting of Post-partum centres in FRUs at sub district levels in

the EAG states, we will address the near universal provisioning of services for fertility regulation. Now we turn to an **expansion in the choice of contraceptives**. Ministry of Health & Family Welfare has already begun to implement this article of the NPP, 2000.We have completed national consultations in respect of the post –coital pill, commonly known as the morning after pill or the emergency contraceptives. A primary recommendation was that the emergency contraception should be introduced into the family welfare programme. I propose that we follow this recommendation, and introduce emergency contraception in the social marketing programme without further delay. Additionally, Ministry of Health & Family Welfare has, in response to a Supreme Court decision, already finalized the modalities for introduction on a pilot basis in 12 medical colleges of the two monthly injectable contraceptive.

5. We wish to address quickly the recurrent shortages in condoms in the EAG states, in particular. The wastages in the storage and distribution network and shortcomings of suitable outlets has aggravated the problem. The need to ensure the rapid distribution of condoms is assuming critical dimensions, particularly to minimize the incidence of AIDS. As a special gesture, I wish to announce that for the first three years, beginning in 2001, the EAG will meet 100% the requirement of condoms in these 8 states. This will enable the states to address the cumulative backlog. However, state governments have a responsibility to ensure meticulous tracking in the field, so that the condoms are in fact accessible and available to the public, as needed and minimize wastage.

Section 6

Minutes of the

First Business Session

MINUTES OF THE FIRST BUSINESS SESSION OF EMPOWERED ACTION GROUP (EAG) HELD ON 18TH JUNE 2001 UNDER THE CHAIRPERSONSHIP OF DR. C.P. THAKUR, HON'BLE MINISTER FOR HEALTH AND FAMILY WELFARE, AT HALL NO-3 VIGYAN BHAWAN, NEW DELHI

The list of participants is enclosed.

After self introduction of the participants one minute silence was observed on the demise of former Union Minister and famous demographer Dr. S. Chandershekhar.

Shri A.R. Nanda, Secretary(FW) gave an overview of the constitution, role and responsibilities of the EAG. EAG is charged with the specific responsibility of enabling preparation of area specific projects in the region covering eight States namely Uttar Pradesh, Uttaranchal, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Orissa and Rajasthan who are lagging behind in containing population growth to manageable levels. The terms of reference of the group cover strategies to be adopted in achieving the above goals. He stressed upon the need to involve NGOs, community based organizations, private sector, Panchayati Raj Institutions in this endeavor.

Smt. Meenakshi Datta Ghosh, Joint Secretary made a power point presentation on the challenge before the EAG, guiding principles, key strategic themes and the proposed convergence of roles and responsibilities of diverse constituents. She emphasized the compactness and contiguity of EAG States, which cover 261 districts within an area of 1.4 million sq. km and a population of 458.67 million. The progress of EAG States in regard to growth rate, female literacy, couple protection rate, sex ratio, antenatal care, safe deliveries and slide on percentage of girls marrying below 18 years of age in these States was highlighted. It was observed that Madhya Pradesh, Rajasthan and Orissa had made satisfactory progress in the last decade. However, Uttar Pradesh and Bihar deserved special focus.

Hon'ble Dr. C.P. Thakur, Minister for Health and Family Welfare described EAG as an "Action" group which would require to galvanise reform in the EAG States after assessing their needs and providing them with the inputs within a timeframe so as to improve the overall social sector development which is a pre-requisite for population stablisation. He said that imposition of incentives and/or disincentives for two child norm is counter productive and also against the spirit of the resolution adopted at ICPD Cairo Conference, to which India is a signatory. Population stabilization must be viewed as a challenge of political vision and commitment, of leadership, social reforms and systemic innovations. HFM announced that the EAG will meet 100% requirement of condoms in these eight States for next three years provided the State Governments ensure minimum wastage and maximum availability to the people, as per their needs. He also announced

the intention of the Government of India to introduce emergency contraception shortly. He promised that Government of India will provide funds to EAG States wherever good, sustainable and innovative projects would be submitted with the intent of improving services to the people. He announced that each State may organize five Health Melas in 2001-2002, for which funds will be made available by Department of Family Welfare. He stressed on the need to implement the PNDT Act 1994 in order to check the selective sex determination and female foeticide.

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Detailed presentations were made by the Member States focusing on the measures being taken by them for reform and their areas of concern:

ORISSA

Ms Meena Gupta, Secretary(H&FW) Orissa, briefed about measures taken by the State Government in ensuring the presence of doctors in the health centres especially in remote areas, imparting multi-skill training to para-medicals, training in anaesthesia to doctors, centralized drug purchase and distribution, constitution of State Health and Family Welfare Society for channeling funds, levy of user charges (except for BPL families) on diagnostics, accommodation and transport facilities made available at hospitals, five diseases treatment and public private partnership adopted by the State in the health arena.

MADHYA PRADESH

Shri Ajay Nath, Secretary(FW), Madhya Pradesh, stated the major constraints in the programme pertain to reach, delivery, unmet needs and community participation. The State Population Policy has been launched in May 2001. It has identified areas for inter-sectoral convergence with Departments of Rural Development, Education, Women and Child Development etc. The district health society will include representatives from NGOs, other Departments, medical practitioners, District Panchayat Boards etc. Nineteen proposals have been received from NGOs for Primary Sewa Kosh Yojna to provide basic health activities in remote areas. The Rogi Kalyan Samiti initiative of the State Government has been given international recognition for improving health infrastructure upto Block levels by charging user fee. The State has introduced a Rational Drug Policy and Training Policy.

RAJASTHAN

Shri B.P. Arya, Secretary (H&FW), Rajasthan briefed about the disincentive scheme adopted by the State Government for two child norm. The State has introduced the Jan Mangal Scheme for community based distribution of contraceptive, the policy of

compulsory three years working in rural areas for Post Graduates(50% Medical Officers) has been adopted by the State. The State has promoted private investment in diagnostic centres, medical colleges, nursing and dental schools. The primary health infrastructure and activities have been decentralized by involving the Panchayati Raj Institutions. Cooperation of the Government of India was requested for funding of State IEC Bureau and for continued funding to SIHFW after IPP IX ceases in December 2001. The issue of revising norms for setting up sub centres/PHCs in remote hilly and desert areas was raised. Shri Arya requested Government of India to consider induction of injectibles in contraceptives and to expand the social marketing concept. Also, the CHCs should be provided with specialists in gynaecology, medicine and paediatrics.

UTTAR PRADESH

Shri Prem Narain, Secretary(FW), Uttar Pradesh, focused on key areas of concern in the programme of population stabilization. ANC coverage and other indicators have improved slightly. Secretary emphasized the need to fill the posts of basic female health worker. The Health Workers (M) have been returned to Health Department from PRI. The State has taken action to reduce MMR by posting additional staff, appointing contractual staff, through 24 hours delivery services, opeationalisation of FRUs and RTI/STI clinics and through referral transport services under RCH. He advocated the need for extending the scheme of referral transport to all villages of a selected Block. Private sector partnership is being experimented in 29 SIFPSA districts. To expand the availability of contraceptives in rural areas a project on social marketing of contraceptives has been awarded to HLL for 15 districts. The State Government has reserved 20% seats to women in Government jobs and fair price shops. The new entrants to Government service will be disqualified if they have more than two children. The State Government has accepted a fixed day approach under which specialists visit CHC. The difficulties faced by the State in implementing various schemes/programmes of the Centre were also raised. They are:

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- CNAA forms are too exhaustive.
- ANM is overburdened.
- No facilities at district level for data transmission
- PNDT Act has no policy of registration of Nursing Homes and Diagnostic Clinics and no funds are given for IEC.

The additional constraints and suggestions to overcome them are as follows:-

Constraints	Suggestion
Reluctance of doctors to undertake	Insurance scheme for doctors

sterilization in view of number of court case filed for failed sterilization operations	
Non-availability of post graduate doctors	MBBS doctors may be permitted to perform laproscopic ligation.
Shortage of lady doctors	Seats for diploma in gynaecology be increased.
Shortage of anaesthetist	Diploma courses in anaesthesia be started
No provision for mobility	Vehicles
ANMs covering upto 8000 population	More sub-centres be built
Less facilities for female education	Funds may be allocated for female education under PMGY
75% expenditure report needed from States for release of next RCH instalment	Should be relaxed to 50-75% of expenditure reported.

UTTARANCHAL

Dr. I.S. Pal, Director General, Health and Family Welfare Uttaranchal, highlighted the issues before the new State. The basic problem is of mobility due to hilly terrain for which State Government requested for the provision of vehicles and POL. Shortage of buildings for sub-centres is also acute. Action has already been taken for convergence within the Department, constituting State Empowered Committee by inclusion of committees of five National Programmes and by appointing doctors and para-medics on contract basis. The State Government also requires support for IEC and logistics.

JHARKAHAND

Mrs. Sunila Basant, Secretary(FW), stated that the newly created state has got 28% tribal population with very low literacy level, shortage of manpower, inadequate infrastructure, insufficient cold chain facilities and faces constraints in information transmission. The State requires new vehicles and vaccine vans. Very few NGOs are working in the state. The State has taken action to keep a watch on attendance of doctors and has also trained the local youth as para-medics. Women volunteers are being trained in Panchayat Swasthya Committee. She strongly advocated the need for revival of licensed medical practitioners.

CHHATISGARH

Shri P. Raghvan, Principal Secretary(FW), identified shortage of doctors as the main problem faced by the State. The State is considering setting up of medical schools where LMP and local youths can be trained after higher secondary exam. The State has

finalized its Population Policy. The Secretary said that EAG must follow self imposed targets to achieve the goals and sought the cooperation of local industry for population stabilization. NGOs should be motivated to work in the tribal belts. He also advocated induction of appropriate information in school curriculum on sex education and for periodic information campaigns in colleges.

After lunch break the discussion focused on the role of different Ministries/Departments of Government of India in the task ahead. The Ministries/ Departments who made the presentations were:-

Department of Women and Child Development

Mrs. Rekha Bhargava, Joint Secretary, Women and Child Development made a detailed presentation on ICDS scheme. She stressed that adequate care, both physical and mental, of the child especially in the age group 0-3 years, is an inevitable prerequisite for economic development of the country. Under ICDS, more than 10 lakh women are working at the ground level as Anganwadi worker and her helper, covering four fifth blocks of the country. Now the scheme has included a component on care of adolescent girls (BPL)in 2000 blocks of the country which takes care of their nutrition needs, training and health problems. Mrs. Bhargava highlighted the scope for undertaking joint training of functionaries of Departments of Women and Child Development and Health and Family Welfare. Further, the ANMs should be asked to sign the register of the Anganwadi Workers whenever she visits the Anganwadi. The IEC material of the two Departments could be shared for better coordination. The SHGs of the WCD can be networked by Deptt. of Family Welfare

Directorate General Of Health Services

Dr. S.P. Aggrwal, Director General of Health Services briefed that a number of steps are being undertaken to fill the gaps in infrastructure and manpower through the System Development Project and Compulsory Rural Service Scheme in the States. The fact is that due to the lack of proper infrastructure young doctors shy away from working in rural areas. He suggested that a scheme to send middle level doctors (who have served for 10-15 years in Government set up) to their respective home towns for two years with extra increment and incentives may be considered so as to make experienced manpower available in the rural areas.

National AIDS Control Organisation

Shri J.V.R. Prasada Rao, Project Director, NACO submitted that AIDS must be included as one of the key components under RCH. If it is neglected, especially in these

eight EAG States, AIDS may emerge as an over riding malaise in future. The awareness on HIV/AIDS is very low (20-30%) in these States. He elaborated upon Family Health Awareness Campaign which create awareness about the disease and services available. He stressed upon the need of creating the awareness for AIDS through STI/RTI which is a part of RCH. Syndrome management is the key to managing RTI/STI. Under the above campaign RTI/STI drugs are made available alongwith the promotion of condoms and follow-up of the cases. He desired that ground level workers and community leaders could be mobilized for spreading the awareness. The Awareness Campaigns could also be used for raising awareness on RCH, Malaria and TB.

Ministry of Rural Development

Shri Wilfred Lakra ,Joint Secretary(Rural Development) accepted that lack of rural connectivity hinders the implementation of the programmes. He informed that under Prime Minister Sadak Yojna, Rs. 2500 crores (non-lapsable fund) have already been released to all the States. He emphasized that the responsibility of managing these funds and building of the roads in underserved areas, rested with the State Governments. Similarly Rs. 2100 crores have been released by the Centre and a matching share from the State under MNEP for drinking water provision, with the guideline to prioritise uncovered inhabitations. Under Swarnajayanti Gramin Swarojgar Yojna, a self help group is given Rs. 10,000 as a corpus fund and RS. 15000/- as a revolving fund. The role of PRIs, SHGs and NGOs is invaluable in implementation of the above schemes.

Department of Elementary Education and Literacy

Shri Vishnu Kumar, Director (Department of Adult Education) briefed on the Population and Development Education Programme launched with the cooperation of UNFPA in 1986. The third phase of the Programme which has started since 1998-2001, has included women empowerment issues, gender bias, small family, STD/AIDS, reproductive health and rights as a thrust area. The programme is implemented by ZSS and State Directorate of Adult Education monitors it. State Resource Centres are responsible for preparation of material and training.

Department of Indian System of Medicine and Homeopathy

Smt. Shailja Chandra, Secretary(ISM) emphasized the need for mainstreaming of ISM in EAG States and stressed the fact that ISM practitioners are already legally practicing under the provisions adopted by the respective States. She cited a study done by the Central Council for Research in Ayurveda and Siddha wherein it has been

found that ISM practitioners are treating antenatal, natal and post natal complications by using ISM practices. While other States have adopted enabling provisions, the States of Bihar and Rajashtan have yet to issue the same. A huge infrastructure of dispensaries (as high as 2189 nos in UP), bed strength (as high as 11396 in UP) and manpower (as high as 91595 in UP) existing under ISM can be efficiently utilized by imparting suitable training to filling the gaps of health infrastructure as it is difficult to make allopathic doctors available in rural areas allover the country. She identified the action points for EAG States as follows:

i) Identify the gaps that exist in respect of availability of medical manpower in PHCs/CHCs and also identify the ISM dispensaries where RCH Programme can be implemented.
ii) Identify the group of ISM practitioners who need to be given training.
iii) Organise training for identified group of ISM practitioners in use of their own drugs and methods and in the use of modern RCH programmes/drugs at selected ISM colleges and Modern Hospitals. The training may be for a period of 1 week in ISM colleges and for a period of 2 weeks in Modern Hospitals.
iv) To equip the identified ISM dispensaries for undertaking the RCH programme and to post the ISM doctor in the PHCs/dispensaries.
v) Providing necessary medicines (both ISM drugs and modern drugs) and condoms, copper T, etc., in the identified PHCs and ISM dispensaries.
vi) To give targets and set up a monitoring system.

The Foundation for Research In Community Health

Dr.N. H.Antia, Chairman and Director, FRCH, made presentation on model of alternative health care system for the EAG States. He pleaded medicine to be treated as a social science and not mere technology. He stressed on utilizing the wisdom of village women for primary health care which he has successfully demonstrated in a cluster of villages in Maharashtra. The neighbourhood groups could be formed, as in Kerala, where a woman works for 50 families in the village. For technical, social and financial sustainability, peoples' sector is the most crucial link. He stressed on the need for investment in the rural areas to be done through Panchayati Raj Institutions. His alternative model stresses on training local women to undertake preventive, curative and counseling services for the community.

Hindustan Latex Ltd.

Dr. M. Arumugam, Consultant, HLL presented a study on suitability of logistics for eight EAG States through a case study of UP and experiences of Tamil Nadu in

logistics management. The objectives achieved in Tamil Nadu were ready availability of drugs to the needy and maintaining strong logistics management system through the computer for activities such as quality control, warehousing, transportation, rationalization, accounting and administration. In Uttar Pradesh serious limitations of logistics, lack of health activities and system deficiencies were identified. The recommendations for system improvement include private sector participation for effective distribution of contraceptives, inviting large industrial units to contribute to the efforts of the family planning and utilizing private hospitals for providing family planning services.

Family Planning Association of India

Dr. Nina Puri, President, FPAI illustrated the need for convergence within the Departments of Govt. of India and State Government, for achieving the objectives of EAG. The group should monitor, facilitate and finance the activities in these eight States by first identifying the five top issues in each State. She highlighted the role of media in the programme. There is a vast area and space for the ISM to bridge the gaps for the needs of the individual and the community for services in health and family planning. The public private partnership should be a joint responsibility in planned action and accountability which can lead to some measure of sustainability.

Voluntary Health Association of India

Shri Alok Mukhopadhyay, Executive Director, VHAI emphasized the need of accepting service in remote areas as a professional hazard by the doctors, similar to postings accepted by officers of the Armed Forces in difficult areas. The doctors must accept service and postings in rural areas if they have accepted the job. He opposed the overloading of periphery worker like ANM with increasing number of responsibilities. He wondered why the funds released by Government of India are not utilized by the State Governments. A better utilization mechanism needs to be ensured. The three newly created States have no infrastructure and resources which should be to provided them on priority. In Uttaranchal, RTI/STI should be given attention as the populace is constantly migrating. In Jharkhand potential of traditional medicine could be explored. He expressed the readiness of NGOs to work in most difficult areas if time, trust and assurance is provided. He stressed on the need of utilizing traditional congregations at fairs and festivals to reach to the masses e.g. Kumbh Mela. Uttaranchal can also mobilize the resources from charitable pilgrims in Haridwar if desired.

SUMMATION

Secretary(FW) informed that the next session of EAG will be held after 3-4 months. It was regretted that the Bihar Government was not represented at the Business Session.

The EAG resolved to work with the participating States in formulating their action plan for improving the service delivery. It was agreed that the plans will be prepared on the basis of the following:

i) State presentations demonstrated that services can be improved by making better use of resources such as mulit-skilling of paramedical workers, multi-use of buildings, improving logistics management, allowing hospitals to retain user charge collections and use the same for facility improvement and so on. In other words, while additional resources may be necessary, the convergence issues must be addressed as first priority. Therefore, proposals for resolving the systemic issues relating to key areas such as human resource management, logistics management, mainstreaming of ISM practitioners, integration of vertical societies at State and district levels, regular release of funds to operational levels, joint planning/training for the field staff of the cognate departments, greater autonomy to the districts and within districts, to hospitals and PRIs will be integral parts of the plan.

ii) Within a State, incremental investments (that may be provided by the EAG) will be focused at bridging the intra-state demographic divide. A key objective in this regard would be to ensure, through a systemic re-structuring of manpower in association with physical improvement, that the distant and sub-divisional hospitals in the backward districts in a States provide the full range of RCH services including 24-hour availability of emergency obstetric services.

iii) The new States- Chhatisgarh, Jharkhand and Uttaranchal – may include in their plans proposals for strengthening their planning and monitoring infrastructure.

iv) A major proportion of the funds available under the Rural Connectivity Scheme, Drinking Water Supply Scheme, the SJGSY Scheme and other Centrally Sponsored Schemes of the Department of Rural Development, will be directed to the backward districts. Proposals for utilization of the Central assistance for these schemes will be integral to the State Plan.

The other significant decision taken by EAG include the following:

i) The Department of Family Welfare will review the CNAA forms and guidelines to make them short and simple. Financial help and technical assistance will

also be made available for fresh training, wherever States expressed such need.

ii) The Department of Family Welfare will review the provisions of the MTP Act vis-à-vis the PNDT Act, to examine whether the provisions of the two may be inconsistent.

iii) The Department of Family Welfare will also review, in collaboration with the Medical Council of India, the standards laid down for laparscopic ligation so as to enable the MBBS doctors to perform such operations.

iv) The EAG will help the States to formulate a suitable indemnity insurance scheme for the public sector doctors to protect them against claims arising from failed sterilization operations.

v) The Department of Family Welfare Link Officers (and the representatives of donor agencies active in the State) will actively participate in the preparation of the State plans. If necessary, the EAG may arrange additional technical assistance for a State to facilitate the plan preparation exercise.

vi) The EAG will give particular attention to systemic changes. In this regard, the EAG will seek to facilitate the change process by (a) appropriate policy development at the Centre, (b) provision of technical assistance to States, and (c) closer monitoring and accountability. Learning from the experience within the country would be a major instrument for replicating systemic changes with due regard to State specific realities and the EAG will facilitate the process of learning through exchange of experiences.

vii) The EAG States will be encouraged to introduce newer contraceptives in a phased manner and , the EAG will seek to mobilize additional resources for this purpose, if necessary.

The Session ended with a vote of thanks by Mr. Gautam Basu, Joint Secretary(RCH).

LIST OF PARTICIPANTS

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2. Shri A.R. Nanda,
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3. Shri J.A. Chowdhury,
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7. Dr. S.P. Aggarwal,
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Section 7

Presentation by

Joint Secretary (Policy)

Empowered Action Group: The Challenge

How to turn a kaleidoscope of competing agencies and programmes into a framework for co-operation?

Three key questions

- How can EAG make a difference?
- How should its energies and resources best be focussed?
- What principles & priorities should guide its work?

Some Guiding Principles

- Consistent with NPP 2000
- Simplify don't complicate
- Effective accountability at all levels
- Build on existing programmes

Key Strategic Themes

- Decentralised planning & programme implementation
- Convergence of service delivery at village level.

Convergence of what?

Roles & Responsibilities

The convergence of roles and responsibilities of the diverse constituent departments. Example: distribution of iron and folic acid tablets in sub centre by ANM can be simultaneously channelised through self help groups and / or the community based frontline workers (AWW)

Convergence of what?

Functions

The convergence of functions.

Example: the elementary education physical infrastructure could be home as much to primary education as to the mid day meal scheme and the immunisation of the below 15 age group, counselling and advocacy

Convergence of what?

Capacity Building

- Supportive supervision for frontline workers. Example: CDPO and ANM
- Joint training. Example: *Panchayat* functionaries, the AWW and the ANM
- Pooling of financial resources.
- Joint Reviews, e.g. health & education

Map of India

% Share of population : Eight States

UP	16 . 17	Orissa	3 . 57
Bihar	8 . 07	Jharkhand	2 . 62
MP	5 . 88	Chhattisgarh	2 . 02
Rajasthan	5 . 50	Uttaranchal	0. 82

Growth Rates 1991 -2001 India : 21.34 %

UP	25 . 80	Orissa	15.94
Bihar	28 . 43	Jharkhand	23.19
MP	24 . 34	Chhatisgarh	18.06
Rajasthan	28. 33	Uttaranchal	19.20

Change in Decadal Growth Rate [India: (-) 2 . 52%]

UP (+)	0 . 25	Orissa	(-) 4 .12
Bihar	(+) 5 . 05	Jharkhand	(-) 0 . 84
MP	(-) 2 . 90	Chhatisgarh	(-) 7 . 67
Rajasthan	(-) 0 . 11	Uttaranchal	(-) 0 . 03

Female Literacy, 2001 [India : 54.28%]

UP	:33.57	Orissa	: 50.97
Bihar	: 33.57	Jharkhand	: 39.38
MP	: 50.28	Chhatisgarh	: 52.40
Rajasthan	: 44.34	Uttaranchal	: 60.60

Growth in Female Literacy
[India: (+) 15%]

UP	(+) 18 . 61	Orissa	(+) 16 . 29
Bihar	(+) 11. 58	Jharkhand	(+) 13. 86
MP	(+) 20 . 93	Chhatisgarh	(+)20 . 87
Rajasthan	(+) 23. 90	Uttaranchal	(+) 18 . 63

Crude Birth Rates, SRS 1999
[India: 26 . 1]

UP	32 . 8	Orissa	24.1
Bihar	31 . 1	Jharkhand	Not av
MP	31 . 1	Chhatisgarh	Not av
Rajasthan	31.1	Uttaranchal	Not av

Couple Protection Rates
[India: 48 . 1 %]

UP	29 . 1	Orissa	49 . 4
Bihar	23 . 4	Jharkhand	27. 8
MP	47. 1	Chhatisgarh	40 . 1
Rajasthan	40 . 5	Uttaranchal	39 . 9

No. of Districts less than 30% CPR

UP	34 / 70	Orissa	1 / 30
Bihar	29 / 37	Jharkhand	9 / 18
MP	3 / 45	Chhatisgarh	0 / 16
Rajasthan	4 / 32	Uttaranchal	0 / 13

Decline in Sex Ratio: 0-6 Years
[India: (-) 18]

UP	: (-) 11	Orissa	: (-) 17
Bihar	: (-)15	Jharkhand	: (-) 13
MP	: (-) 12	Chhattisgarh	: (-) 9
Rajasthan	: (-) 7	Uttaranchal	: (-) 42

Girls marrying before 18
[India: 36.8%]

UP	49.3	Orissa	32.2
Bihar	58.2	Jharkhand	50.8
MP	58.6	Chhatisgarh	41.9
Rajasthan	57.1	Uttaranchal	12.4

Any Antenatal Care [India : 67.2%]			
UP	48.0	Orissa	: 72.9
Bihar	26.4	Jharkhand	42.8
MP	53.9	Chhatisgarh	52.2
Rajasthan	62.0	Uttaranchal	40.6

No. of Districts without any Antenatal Care			
UP	14 / 70	Orissa	0 / 30
Bihar	21 / 37	Jharkhand	4 / 18
MP	5 / 45	Chhatisgarh	0 / 16
Rajasthan	1 / 32	Uttaranchal	0 / 13

Safe Deliveries India: 41.9%			
UP	21.9	Orissa	: 32.9
Bihar	18.8	Jharkhand	: 19.9
MP	29.5	Chhatisgarh	: 22.4
Rajasthan	33.5	Uttaranchal	: 22.3

Numbers of districts less than 30% Safe Deliveries			
UP	: 34 / 70	Orissa	14 / 30
Bihar	: 23 / 37	Jharkhand	: 10 / 18
MP	: 15 / 45	Chhatisgarh	: 4 / 16
Rajasthan	: 6 / 32	Uttaranchal	: 0 / 13

Thank You

Section 8

Presentation by

Health Secretary, Rajasthan

Initiatives And Strategies For Population And Family Welfare Programme In RAJASTHAN

B.P. ARYA
Health Secretary
Government of Rajasthan

Socio – Demographic Profile

	India	Rajasthan
Population (In Million)	1027	56.5
Pop Density	324	165
Sex Ratio	933	922
Literacy Rate	65.38	61.03
Female Literacy	54.16	44.34
Decadel Growth	21.34	28.33
TFR[1998]*	3.3	4.1
CPR [2000]**	45.4	37.0

Source: Census Publication, 2001

* SRS Publication, ** DHS, Jaipur

State Population Policy Goals

Indicator	2004	2011	2016
• Crude Birth Rate	27.5	22.6	18.4
• Total Fertility Rate	3.41	2.65	2.10
• Couple Protection Rate	48.2	58.8	68.0
• Infant Mortality Rate	72.7	62.2	56.8

State and National Population Policy Goals

Indicator	Rajasthan	India
	Year 2016	Year 2010
• Crude Birth Rate	18.4	21.0
• Total Fertility Rate	2.1	2.1
• Couple Protection Rate	68.0%	60.0%
• Infant Mortality Rate	56.8	< 30
• Institutional Delivery	50%	80%

Status of Health & Family Welfare in Rajasthan

Indicator	1995	1996	1997	1998	1999	2000
CBR	33.3	32.3	32.1	31.6	31.1	
CDR	9.1	9.7	8.9	8.9	8.4	
IMR	85	86	85	83	81	
MMR	4.56	-	6.77	-	-	-
TFR	4.5	4.4	4.2	4.1	-	-
CPR	30.2	30.7	33.0	34.0	35.8	37.0

Family Welfare Programme Performance 1995-2001

Year	Sterilization	IUD	Condom	Oral Pills
1995-96	168245	168239	519048	125230
1996-97	200711	204765	722682	204283
1997-98	224140	224100	869431	313664
1998-99	229019	234629	995378	374280
1999-00	226272	238720	963802	426787
2000-01	268396	240436	466714	395754

Addressing unmet need of Family Planning and RCH Services

- Two child norms for public representatives effective from 27 Nov, 1995
- Wider Network for Contraceptive Distribution
  - Open counters at health institutions
  - CBD through Jan Mangal Couples
- MTP Services through 266 Govt and 259 Private Institutions
- 212 Static centres functional for sterilization and IUD Insertion

Cont. Addressing Unmet Need of Family Planning & RCH Services

- 90 Health Posts in urban areas in 11 districts for family welfare services
- Promotion of Male Participation – 100 doctors trained in NSV technique
- 24 Hours Delivery Services in all 32 districts
- Referral Transport in 18 districts
- RCH Camps in 11 Districts
- Dai's training in 6 districts

Strategy to Improve FW Programme Management

- Ensuring quality care services
- Focus on couples with unmet need
- Focused attention on poor performing PHCs and sub-centres
- Improve logistics management
- Improve accessibility to services
- Skill up-gradation of service providers
- Supportive supervision

Inter-Sectoral Convergence

- 19 Govt. Deptts. Involved in State Population Policy Implementation : Roles and action plans developed
- PRI's given administrative control of PHCs/SCs
- Active involvement of Ayurved Ausdhalayas, AWCs and Dairy Cooperatives for contraceptive distribution and promotion of Family Welfare issues.
- Involvement of NGOs/Private Sector
- Involvement of school teachers, social and religious leaders for environment building for small family

Reduce Infant Mortality

- New born care
- Improve complete immunization to a level of 90-95%
- Diahorrea control – Widen network for ORS distribution
- ARI control & management
- Effective implementation of ICDS Programme.
- Availability of trained Dais at village level.

Reduce Maternal Mortality

- Ensure 100% registration of pregnancies
- Minimum one visit by ANM after delivery
- Increase institutional deliveries
- Ensure 15% referral of obstetric emergency
- Referral transport for emergency obstetric cases
- Strengthening and expansion of MTP services
- Ensure proper nutrition to pregnant women through ICDS
- Implementation of Maternal benefit scheme

Innovative Scheme Under Family Welfare in Rajasthan

Jan Mangal – An intervention for CBD

- Pilot Project in 1992-93 in two districts
- Expanded in phased manner covering entire state
- 13272 Jan Mangal Couples presently working.
- 2.41 lacs eligible couples being benefited

Major Issues for Future Support from GOI

AFTER IPP-IX IN RAJASTHAN

- Funding to State IEC Bureau for organizational set up and ongoing activities.
- Funding to SIHFW for organizational set up and ongoing activities.

POPULATION CONTROL

- Scheme for Social Marketing of Contraceptives.
- Provision of Injectible Contraceptives

INFRASTRUCTURE

- Creation of CHCs, PHCs, SCs as per population of Census, 2001

Section 9

Presentation by

FW Secretary, UP

Family Welfare Programme

in

Uttar Pradesh

Innovations and Experience

Results of Coverage Evaluation Surveys

Items	NFHS-I	NFHS-II	RHS
Infant Mortality Rate	9.9	86.7	--
Child Mortality Rate	46.0	39.0	--
% of ANC Coverage	44.4	34.6	48%
Children fully Immunized	19.8	21.2	44.5%
% Institutional Delivery	11.2	15.7	--
$ Safe delivery	17.2	23.0	31.23
CPR [all methods]	20%	28.1%	29.1
TFR	4.8	3.9	--
TT 2 Doses Pregnant Women	37%	51.4%	--

Birth Rate and IMR [UP]

Year	BR	IMR
1951	38.6	--
1961	41.5	179 [1969]
1971	44.9	202 [1972]
1981	39.6	150
1991	35.7	97
1998-1999	32.4	85

Staff Position – Family Welfare [UP]

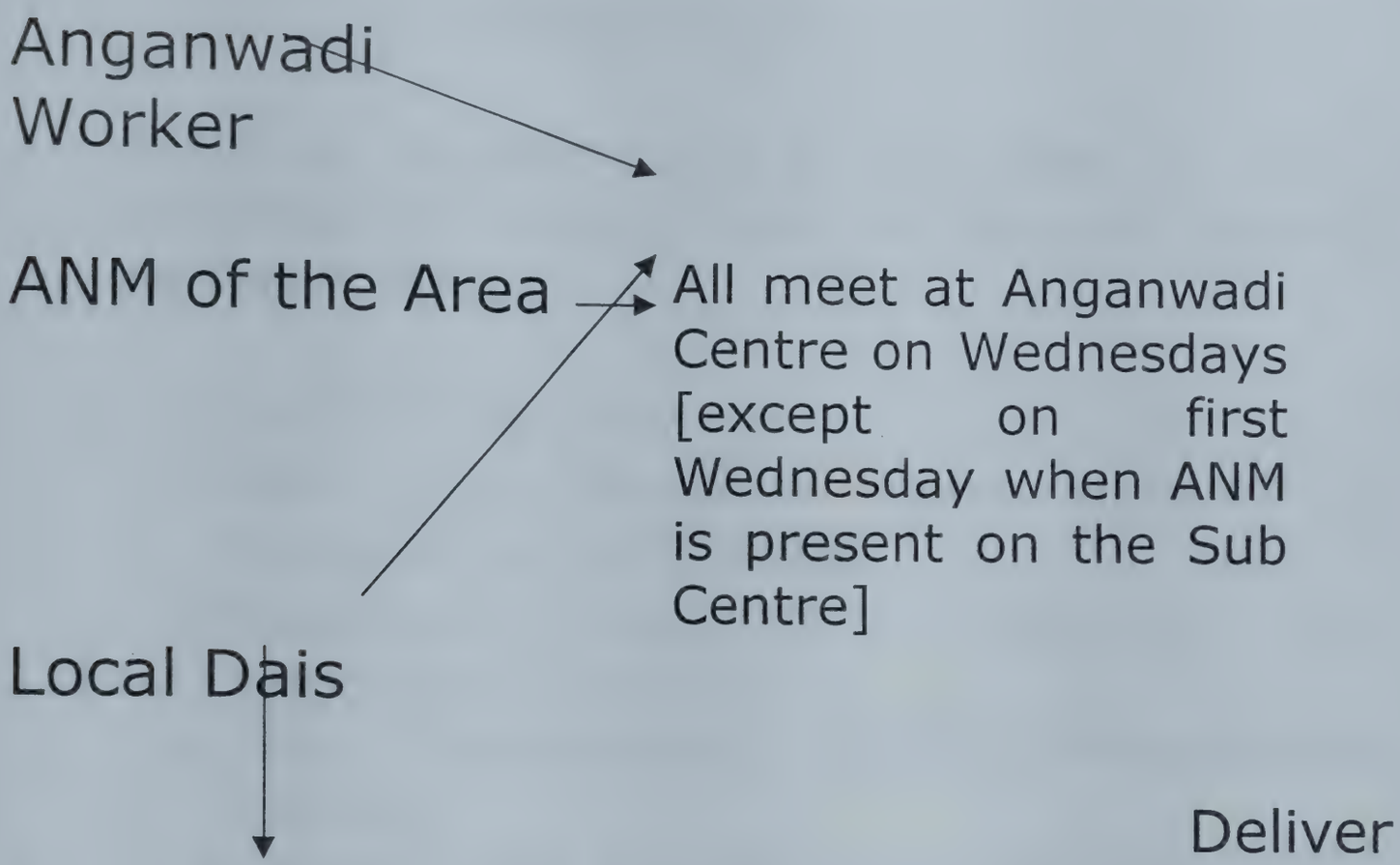
Sl. No.	Posts	Sanctioned	Posted	Vacant
1	BHW (F)	21877	21577	300
2	Health Supervisor [F]	3691	1291	2400
3	Health Supervisor [M]	5754	4434	1320
4	HEIO & Dy. DHEIO	1131	665	466
5	DHEIO	57	28	29
6	AO	53	32	21
7	ICC	1145	1083	62
8	SA	16	8	8
9	BHW [M]	All BHW[M] have been transferred to Panchayati Raj Departments		

RCH Interventions to Reduce MMR in UP

1. Posting of additional staff in the field to strengthen the facilities for the community
   - Appointment of Contractual ANMs at 30% Remote Sub Centres – 2824 in 48 distt.
   - Appointment of Staff Nurses/PHNs at Block Level PHCs 370 in 48 Distt.
   - Appointment of Contractual Safe Motherhood Consultants to visit Block PHCs & CHCs on fixed days. – 48 in 24 distt.
   - Appointment of Contractual Lab Technicians at FRUs – 2/District 48 in 24 Districts
2. 24 Hrs Delivery Services [at selected 4 units of the District] – Operational in 40 District

3. Operationalization of FRUs – 44 FRUs in 25 districts functional.
4. Operationalization of RTI/STI Clinics – 19 Districts
   - Kits not yet received
   - Training non conducted by NIHFW
5. Referral Transport Services at 600 Gram Panchayats of selected 9 Districts.
   - Scheme should be extended to all villages of a block.

CONVERGENCE APPROACH IN RCH



Deliver Services

- Take Home Ration day
- Weight recording – Mother & Babies
- Immunization - Pregnant women & Babies
- IFA Distribution
- ORS as per need
- Contraceptive distribution
- Family Planning Advise
- Counseling regarding safe delivery
- Counseling regarding Nutrition and development.

PRIVATE SECTOR PARTNERSHIP

SIFPSA DISTRICTS

- Is being experimented in the field of family planning to expand use of modern spacing methods through

  - NGO's CBD Worker's
  - Milk Cooperatives – Large Network of Cooperative Volunteers
  - Organised Industries – Workers and community around
  - ISM Practitioners (8938 Practitioners trained)
- 118 NGO's and Cooperative projects funded and 8000 women volunteers recruited so far
- Additional Users made till March 2000 through this approach
  - 441339 - Condom Users
  - 348021 - Oral Pills Users
  - 22816 - IUCD Users

PUBLIC – PRIVATE PARTNERSHIP IN SIFPSA SUPPORTED DISTRICTS

- Private Lady medical officer hired to serve at PHC's and CHC's where post of LMO lying vacant.
  - Two visits a week in CHC's and once a week in PHCs made by LMO's in 15 SIFPSA Districts.
  - Above scheme extended in RCH Programme presently in 24 districts
  - Total 86 private LMOs employed

- Formulation of District Action Plan in 6 SIFPSA Districts since March 1988 through Districts Societies.
  - DAP resulted in improved performance in
    - Family Planning (Spacing Methods)
    - Quality of service delivery
    - Access to RCH Services
  - Districts Action Plan approach now extended to 9 more SIFPSA districts

SOCIAL MARKETING OF CONTRACEPTIVES

- Aims to expand availability of condoms and oral pills in rural areas in private sector to cover unmet need of eligible couples

- 3 year's Social Marketing Project awarded to Hindustan Latex Limited in 15 Districts in March 1997

- Sales being expanded by opening new out lets and through linkages with NGOs and mil co-operatives in rural areas

- Till March 2000, 77.5 Million pieces of condoms and 860000 cycles of oral pills sold under social marketing in these 15 districts.

- There exists potential market for 13 million cycle of oral pill & 136 million pieces of condom in UP

- Project has been extended for further period of 3 Yrs. In whole of UP.

BOTTLENECKS IN OPERATIONALIZATOIN OF CNAA

- CNAA Forms for ANM are too exhaustive and complicated Need to be simplified.
- Time Schedule for Survey for Making action Plan in the month of March not practical as March is very busy month for field workers.
- Too many Campaigns leave no time for survey of families by ANM.
- No financial assistance for printing of nearly 2.80 Crores survey forms every year for doing survey prior to making of Action Plan at grass root level.
- ANM and computers not rained for filling data in the CNAA format and making Action Plan. Training needs to be done again.
- NIC in Uttar Pradesh has no Software to train district personnel in data entry and transmission through NICNET.
- Reports on various other formats are still being asked by different programme officers at Govt. of India level, even after introduction of CNAA Form No.9 (i.e. monthly reporting format)
- No computer and internet facilities exist at District level to facilitate data transmission.

DIFFICULTIES IN IMPLEMENTATION OF PNDT ACT 1994

- Only Genetic clinics, Genetic Laboratories and counseling centers are required to be registered under the Act, which are difficult to be identified.
- State has no policy of registration of Nursing Homes and Diagnostic clinics including ultra sound, hence registration of genetic centres is proving difficult.
- Doctors and technicians even if running a genetic clinic or laboratory, do no disclose this during enquiry.
- Registration of these centres is almost nil due to above reasons.
- Appropriate authority has not been provided any assistance under the ACT who can file the cases in the court and follow prosecution as in Food Adulteration Act and Drugs and Cosmetic Act.
- No funds for TA/DA for members of advisory committee who have to meet every 60 days.
- No provision of security for Appropriate authority while doing raids or making searches and seizure of documents on centres acting/running against the provisions of the Act.
- MTP Act 1971 proving counter productive in implementation of PNDT Act.
- No funds for publicity and awareness generation programmes made available by Govt. of India so far.

CONSTRAINTS IN FAMILY PLANNING PROGRAMME IN UP

CONSTRAINTS	SUGGESTIONS
1. Increasing number of court cases against doctors for failed sterilization operations, making surgeons apprehensive.	Some sort of Insurance Scheme be started for doctor performing Sterilization operaytion.
2. Non availability of post graduate doctors/ lady doctors for Laproscopic ligation	MBBS doctors be allowed for doing Laproscopic ligation.
3. Shortage of Lady doctors in Govt. service	Seat for Diploma Course in Gynaecology (DGO) be increased in Medical Colleges in Uttar Pradesh for service doctors.
4. Shortage of anesthetist in Govt. service	Short Certificate or Diploma Course in Anaesthesia be started in Medical Colleges in Uttar Pradesh for service doctors.
5. No Mobility provision for middle level supervisors (Dy. CMOs)	Districts Immunization Officer and Dy. CMO [FW] be provided vehicle.
6. Restriction on release of RCH funds, till 75% of expenditure report made available to GOI	Condition to be waived off or reduced from 75% to 50%
7. Establishment of Subcentres not as per GOI norms. ANMs presently working on more than 8000 population instead of 5000 population	Govt. of India should provide assistance for establishing more sub centres as per norm.
8. No funds for quarterly programme review meetings.	GOI should provide financial assistance.

9. 2/3 Sub Centre working in rented private building not suitable for s/c work.	GOI should sanction construction of Govt. subcentre building.
10. Less facilities for female education.	Female education has special role in promoting FW Programme. Therefore, under PMGY special allocation be made for female education by GOI directly.

Section 10

Presentation by

DG (Health), Uttaranchal

Department of Medical, Health and Family Welfare Uttaranchal

First Business Session, EAG
New Delhi

[Convergence of services and modalities for integrated service delivery at grass Roots level and to increase outreach]

Introduction

- 27th State, came into existence on Nov 9, 2000
- Economically backward in spite of rich natural resources
- Constant out migration of males
- 13 districts, 2 divisions, 49 tehsils
- 1.7% of countries land area but less than 1% population
- Population density: 159 [2001] and 133 [1991] Haridwar 612 – Uttarkashi 37
- Total population 84.79 lac, Male 43.16, Female 41.63
- Decrease of decadel growth from 24.23 to 19.20
- Literacy rate 72.28 [2001] compared to 57.75 in 1991
- CBR 19.6 [SRS] and CDR 6.5 [SRS]

- CPR 49.4 [RCH 98]
- IMR 52 [SRS]
- 84.01 males and 60.26 females are literate
- 936 [1991] and 964 [2001] females per 1000 males
- % of villages not covered with pucca roads 62
- Age of marriage [% women married before age of 18] 15
- % of birth of order 3 and above 49.1
- Unmet need 31.7%
- Safe deliveries 51.2%
- Institutional Delivery 38.9%
- Complete immunization 64.9%
- Females with symptoms of STI 11.9
- Knowledge of females on AIDS 66.6%

Opportunities

- Formed on concept of small unit development, has less than 1% of national population
- 5.8% of villages > 1000 and 32.3 having population 200 to 499
- Remarkable improvement in sex ratio during last decades I.e. 936 to 964 female/1000 males [28 point]
- Significant growth in literacy 72.28 [2001] compared to 57.8 in 1991
- CBR 19.6, CDR 6.5 and IMR 52 at par with most advanced States of the country.
- ¾ households having safe drinking water, though distance of water sources is a permanent feature in Uttaranchal Villages.

Challenges

- Scattered inhabitation in the land of icy mountains, hilly tracks and undulated terrain's resulting very difficult access to services.
- More than 62.5% of villages are not connected with pucca roads, lack of communication. This leads to vicious circle of under development and poor infrastructure.
- Ratio of population having safe drinking water in last decades are declining due to deforestation and related problems.
- Only 8.85 to 52.91 households are using proper toilets, in rural segments it goes down as low as 3.59% in PTH.
- Only 19.44 to 54.59% households in rural areas are connected with electricity

- Above lead to poor health infrastructure and man power availability. Out of 6783 gram sabha's 4922 are not having any static health service delivery
- In State 17.70% households still do not have access to basic amenities such as electricity, safe drinking water and proper toilet.
- There are 23 CHCs, 84 BPHCs, 173 new PHCs and 322 allopathic dispensaries, normally manned by at least one doctor, only 290 out of 602 units are manned by one doctor.
- High prevalence of TB, Malaria in endemic area and leprosy. The prevalence of TB is 1225/Lac population [RCH] in comparison to 514/Lac national prevalence [NFHS-2]
- Magnitude of problem is much deeper besides poor infrastructure, lack of facilities, inadequate manpower, low financial resources.

Strategy for convergence and integrated service delivery

- Convergence of all social services at village level for capacity enhancement.
- Inflow/Out flow information dissemination including proper HMIS
- Capacity building of village based workers
- Integration of medical therapies
- Increased mobility of referral and medical services
- Development of village based minimum health support system
- System for continuous training and management input through sustainable socio-medico based institution like Institution of Health on successful Philippine model

Convergence

- ICDS: Birth & death information, health and hygiene awareness, ANC/PNC conduction, awareness towards RTI/STI, distribution of Vit. A and Iron
- DWARA: Health awareness, distribution of Iron & Vit A, identification of unvaccinated households, referral for safe delivery
- NFE: school health program, promotion of vaccine, support by NFE instructor to panchayat for record upkeep
- SHGs: Utilization for management issues in outreach services, IEC partnership, informal informers of health programs
- Panchayat: Forum for health program, creating conducive environment, record keeping for health indicators, coordinating different social delivery activities and staff.
- Adult Education Program: Motivation to eligible couples, demystification of myths and beliefs among elder groups, holding voluntary camps for cleaning of village water resources

- TBA: conducting safe deliveries, identification of high risk pregnancies and referral, control of RTI in neonates, IEC for RCH
- CHG: To help in record keeping with panchayat, village level contraceptive stocks maintenance including social marketing, to provide treatment of minor illnesses
- Schools: conducting school health program, identification of infectious diseases in children and notification to nearest health center, child to parent health and hygiene activities
- Village Social groups: conducting camps, meetings, help in transportation of high risk mothers and emergencies
- Joint Forest Management Committees: Mass aforestation program to promote clean and healthy environment
- ISM Practitioners: contraceptive marketing, referral of complicated deliveries

Actions taken in Uttaranchal

- Formation of State Empowered Committee its registration and functioning. There are 5 sub committees under SEC for TB, Blindness, RCH, AIUDS and Leprosy
- Cabinet decision held and process started for recruitment of 292 doctors on contract basis and paramedical [staff nurse, lab technician and X-ray tech] also for all FRUs
- For basic minimum health delivery a comprehensive 10 days training has been given to 1733 Anganwadi [ICDS] workers and 1428 CHGs. Out of these 1571 and 813 has been supplied kits.
- The Secretary of Medical Health is also looking after the Department of Ayurveda, Homeopathy, ICDS, drinking water for effective convergence at state level.

- District Action Plan as per community need assessment has been made by all districts of Uttaranchal and State Plan is also ready.
- 4 Ayurvedic and 2 allopathic master trainers made for dissemination of training on ISM
- PMU for health system project [WB supported] established
- Provision has been made in state budget for the constructions of 40 sub centre buildings, 10 PHCs and establishment of 6 CHCs, 3 CMOs, 5 TBCs during this financial year.
- A pilot project supported by UNICEF has started under NGO sector in one block of Dehradun district under concept of "Parivar Swasthya and Poshan Saheli", one saheli looks after needs of 15 families.

Section 11

Text of the address by

Director (DAE), D/Elementary Education and Literacy

Text of the address by
Director, Department of Elementary Education and Literacy

The Project on Integration of Population Education with Adult Literacy Programme was launched in 1986 with the financial support of United Nations Fund for Population Activities (UNFPA). The implementing agency for the Project is the Directorate of Adult Education. It gets necessary guidance from Ministry of Human Resource Development and National Literacy Mission. The nodal agency is the Department of Family Welfare in Ministry of Health and Family Welfare which coordinates all projects relating to population education including those being implemented by National Council for Educational Research and Training (NCERT) and University Grants Commission (UGC).

The first phase of the project was for five years from 1986. The actual implementation began after a preparatory phase of one year from January 1987. This phase was to last upto 1991 but because of the delay in conducting evaluation of the project by an external agency, the activities were continued upto 1993. Based on the recommendations of the evaluation, the project period was extended upto 1996.

The project period from 1994 to 1996 constituted second phase. However, the second phase concluded only at the end of May, 1998.

The third phase of the Project started from June 1998 for a period of 43 months i.e. upto the end of the year 2001 and is titled Integration of Population and Development Education in Post-Literacy and Continiuing Education. The Code No. for the third phase is IND/97/P32

The focus of the project during the first phase was on developing and strengthening the capabilities of the resource agencies and the administrative bodies to organize Population Education through the on going literacy programmes. Thus, creation of infrastructure at the national and the state level, initiation of steps to institutionalize Population Education in their various activities by preparation of curriculum, development of materials, conduct of training and organization of extension activities received major attention. Apart from developing printed materials, the emphasis was also given on developing materials for motivational purposes through the use of audio-visual aids, organization of exhibitions, reach out activities and so on. The activities related to the first phase were carried out through center based approach where the teaching/learning process for adults in the age group 15-35 was organized.

The Adult Education Programme implemented in the country was on center based approach and hence the integration of population education messages were

through the literacy primers used in the Centres for the learners. The messages were broadly on small family norms, responsible parenthood, right age of marriage, population growth and environment, population and development and beliefs and traditions. These messages were also inter-woven in the training curricula for the adult education functionaries.

The broad strategy followed by the State/Regional Resource Centres was integration of the Population related messages and priority areas appropriately in the primers prepared on the Improved Pace and content in Learning (IPCL) formula. The messages also were incorporated in the motivational, supplementary and follow up material like posters, street corner plays, puppet shows, books and booklets, flip charts, comics, stories, etc.

In order to deliver the messages properly to the learners in the centres, the training curricula for adult education functionaries included the important population related aspects demographic situation and its effects, environment pollution, afforestation, small family norm, mother and child care.

In order to make the teaching/learning more attractive and to reinforce the population related messages in the learning materials, almost all the State/Regional Resource Centres developed imaginatively conceived and attractively produced audio and video programmes for use both in broadcast/telecast mode and non-broadcast/telecast mode. Through extension/reach out activities also the State/Regional Resource Centers tried their level best to convey the messages to the community in general and the learners of adult education centers in particular.

The implementation strategies for Adult Education Programme in the first phase was mainly based on centre-based approach but due to a major shift in the Literacy Mission, the project activities were geared to the campaign based programmes of literacy and post literacy during the second phase of the Project. The emphasis of the project in this phase was, therefore, directed towards the goals set forth in the National Literacy Mission and it also reflected the priorities set out by the nodal agency. i.e. Ministry of Health and Family Welfare (MHFW). ***The districts identified by the MHFW having high infant mortality rate, disproportionate sex ratio, high crude birth rate and low mean age of marriage were given precedence during the second phase.*** The project tied up with the literacy campaigns districts so that there is a convergence of efforts for promotion of literacy and for reduction of population growth rate.

The other dimensions focused were related to Information, Education and Communication IEC) activities on the emerging areas of national concerns which

covered issues such as gender bias, inter-spouse communication, women empowerment, STD, AIDS etc.

In view of high rate of participation of women in the literacy programme and also realizing the significance of women's role in ensuring better quality of life, the issues related to women empowerment, gender equality, reproductive health and rights, family life education etc. are included as additional thrust areas.

Since the literacy campaign in several of the districts have concluded successfully and a large number of neo-literates have now entered into post-literacy and continuing education stages of learning respectively. The organizational structure available for them in the form of post-literacy and continuing education centres serve as nuclei for providing more intensive exposure for the third phase of the project "Population and Development Education in Post-Literacy and Continuing Education".

The following thrust areas of the first and second phase of the project continued to have emphasis in the third phase also. The areas are :

1. Small family norm
2. Responsible parenthood
3. Right age at Marriage
4. Population Growth and Environment
5. Population and Development
6. Beliefs and Traditions
7. STD and AIDS
8. Gender Bias
9. Inter-spouse Communication
10. Women Empowerment

In addition to the existing thrust areas indicated above, new thrust areas for the third phase are :

1. Reproductive Health and Reproductive Rights
2. Fostering Human Dignity
3. Adolescent Reproductive Health/Sexuality Education
4. Family Life Education
5. Preventive & Curative Education for STD & AIDS

***

Section 12

Text of the address by

DG, Health Services

First Business Session of the EAG

Text of the Address by Dr. S. P. Agarwal, Director General, Health Services

Notwithstanding the development of an elaborate primary healthcare system in the country, gaps still exist. The unmet needs for primary healthcare infrastructure for the projected population in 2002 have been estimated as 23190 sub centres, 4212 Primary Health Centres (PHCs) and 3776 Community Health Centres [CHCs]. This according to the National Population Policy 2000, would involve additional funding requirement of about Rs.4748 Crore as capital and Rs.1683 Crore recurring every year.

For filling up the gaps, establishment/strengthening of secondary level health care hospitals [district hospitals/CHCs] through institution of state health systems projects with external funding assistance, wherever required, should be considered. These district hospitals and CHCs should work as first stage referral units in addition to being centres for follow up of patients referred back from tertiary level hospitals. Regarding high quality tertiary care facilities, there is a case for involvement of private sectors with adequate safeguards, to ensure proper standards at reasonable costs.

According to the National Population Policy 2000, there is a significant unmet need of doctors, especially in the rural areas. The shortage of medical officers estimated at 2475, specialists estimated at 6635 and paramedics is an important factor affecting effectiveness and utilization of the various CHCs, PHCs and Sub-centres. Even in 8 States that are being considered by Empowered Action Group. There is a shortage of 1854 doctors at PHC and 2511 specialists. Further, among the specialists, there is an acute shortage of anesthetists who are essential for emergency surgical management of Obstetric and other emergencies. Similarly, there is an acute shortage of Forensic Medicine experts also. The financial requirement to address the unmet needs for trained health manpower have been estimated in the National Population Policy 2000, document at Rs.2300 Crore.

In view of the shortage and mal-distribution of medical officers and specialists, State Governments have taken various steps like making rural service obligatory, posting of all medical officers in rural areas for a period of 3 years, reservation of Postgraduate (PG) medical seats for doctors who have worked in rural areas, compulsory posting of doctors for one year before being allowed to join PG medical courses etc.

There are nearly 8000 postgraduate medical seats in the country against 17,000 MBBS doctors qualifying from 167 medical colleges each year. There is a natural tendency for these medical graduates to work in the larger hospitals located in the urban areas to be able to compete and

get into the post graduate courses through various examinations, especially when they are paid reasonable emoluments while pursuing these courses.

Leaving aside the existing vacancies at PHCs, it is a matter of common knowledge that even the doctors posted in the rural areas are not able to delivery health care services for various reasons like lack of their acceptability among the rural population, inadequate housing facilities, non-availability of drugs, lack of investigation facilities like labs etc. and lack of proper schools etc. Even the expectation regarding the ability of non-experienced young doctors trained in "evidence based medicine" in medical colleges located in urban areas, to effectively treat patients independently in the PHCs in the rural settings without proper investigation facilities itself appear "unrealistic".

It may be appropriate to send middle level doctors [with 10-15 years of experience in Government service] to their respective hometown located dispensaries/PHCs/CHCs on a tenure basis for one or two years. Of course, these middle level doctors may be given incentives like an extra increment, and permission to visit their families back in the cities for 2-3 times in a year. Also, the option of choosing the area depending on their family commitments, a particular period of their career when they would like to go to these rural areas, can be offered. These doctors with adequate experience along with their commitment to their native place and also people's faith in such [their own] doctors, will be able to provide the desired services in the rural areas effectively.

In view of the above, while compulsory posting of young doctors for one or more years is not serving any public interest, the posting of middle level doctors, as suggested above, will not only ensure availability of experienced and committed doctors but also raise the standard of medical services in the rural areas.

The overall shortage of specialists in branches like Anaesthesia, Forensic Medicine, Pre-clinical subjects etc. could be overcome by giving adequate incentives to students pursuing further studies in unpopular medical branches and continuing their service after completion of PG course.

Section 13

Presentation by

HLL

Broadline™

HOME

Logistics Management System

Experience of T.N & a case study of U.P.

For family welfare commodities namely

- Condoms
- Copper T
- Oral Pills
- Iron & Folic Acids
- Oral Rehydration Salts (ORS)
- RCH commodities

By.,

Dr. M. Arumugam M.E. MBA. Ph.D

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What is Logistics ?

" Responsiveness, reliability and relationships - the basis for successful logistics "

- ✓ Process of
  - ➢ Procurement
  - ➢ Materials Management
  - ➢ Warehousing
  - ➢ Transportation
  - ➢ User access
  - ➢ Information Technology
- ✓ Results in complete supply chain

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Tamilnadu Experience

A model has been established in Tamilnadu (TNMSC) with the primary objectives of ensuring:

- Ready availability of drugs and suture materials in all Govt.Medical Institutions
- To make the drugs available to the needy
- The activities such as
  - Quality Control
  - Warehousing
  - Transportation
  - Rationalization
  - Accounting & Administration

are through the computer for total error free strong logistics management system

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Tamilnadu Experience

Entire Operations of TNMSC were Computerized and some of the Operations are Web enabled namely

- ✓ Electronic Tendering
- ✓ Stock Monitoring
- ✓ Supplier Information System - Supply Chain

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Tamilnadu Experience

- The solutions starts from the identification of Drugs to Management Information System
- Computerization was introduced first at the headquarters then extended to all the warehouses
- The software is developed with ORACLE database and the power of Visual Basic in WINDOWS NT Platform

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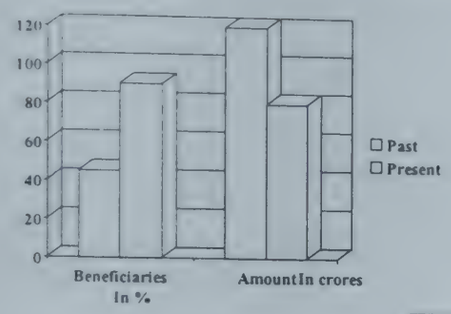
Trend Analysis – Before & After Computerisation



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TNMSC & Broadline

Some of the
AWARDS & APPRECIATION

RAJIV GANDHI NATIONAL QUALITY AWARD, 1996

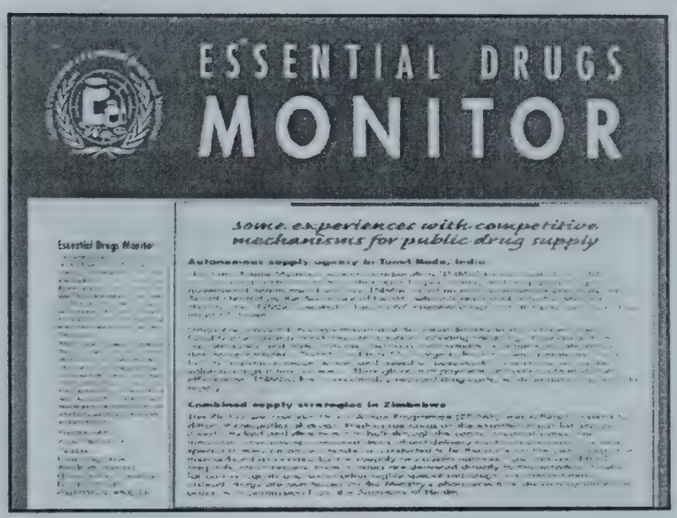
(Service Sector)

AWARD WINNER

K. SRINIVASAN
Secretary to Government of India
Department of Consumer Affairs
Chairman
National Awards Committee

SUBJIT SINGH BARNALA
Union Minister of Chemicals & Fertilizers
Food and Consumer Affairs and
President
Bureau of Indian Standards

New Delhi 13 March 1999



TÜV

CERTIFICATE

The TÜV CERT Certification Body
of Rheinisch-Westfälischer TÜV e.V.
hereby certifies in accordance with TÜV CERT
procedure that

TAMIL NADU MEDICAL SERVICES
CORPORATION LIMITED
Whites Road, Mamotha Complex, III Floor
Royapettah, Chennai 600 014, India

has established and applies a quality system for

the procurement, storage and distribution of Drugs
Medical Stores and Provision of Diagnostic Services

RWTÜV

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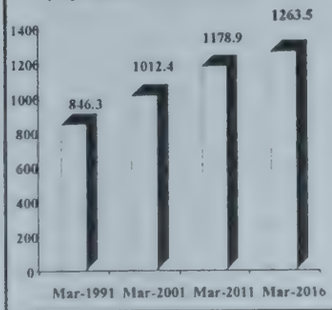
Indian Scenario - Population

India's population in 1991 and projections to 2016 - In millions



- It is estimated that there will be a increase of about 49% in the population in about 25 years
- This growth pose serious limitations in family welfare & family planning methods
- The government concentrates in the development of health infrastructure in the neglected 74% of the rural population

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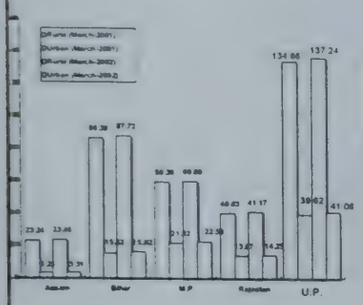
U.P. Experience



- U.P registers a high population growth compared to other states
- Population of U.P

	Rural	Urban
2001	134 million	39 million
2002	137 million	41 million

- Estimated population increase in a year
  - Rural : 2.5 million
  - Urban : 2.0 million
- This rapid rise of population pose a threat to the stability and growth of the economy

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U.P. Experience

Logistics Limitations :

- The health care product distribution in U.P reveals serious limitations of logistics
- This results in non availability & sometimes abnormal supplies of products in most health centers
- The requirements are not based on any actual consumption figures
- The requirement are arrived by adding 20% to the previous supply without taking into account the current balance

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U.P. Experience

Lack of health activities :

- The male health workers are deputed for panchayat bodies
- The ANMS are overloaded with many other schemes
- The health educators are mostly not placed in CHC,PHC and sub centers
- Manning of contraceptive distribution and training is not very much active
- Lack of coordination

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U.P. Experience

System Deficiencies :

- Wastage with respect to storage, time expiry & transportation
- Mismatch in supply & demand
- In most of the Health centers the Book stock & the Physical stock does not tally
- PHC's are serving excessive population, beyond the limit set out by the GOI
- There is no I.T model

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U.P. Experience

System Deficiencies :

- No speedy sanction of financial matters
- Lifting of stocks by their own transport
  1) CMO from LMC
  2) PHC & CHC from CMO
- Mostly transportation is not available freely in CMO's,CHC's,PHC's etc
- No Feedback system
- No coordination with promotion and availability stock

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U.P. Experience

Essential Weak Links :

- Enhanced Requirements
- Disorganized Distribution
- Irrational selection
- Wastage of Stock - Time Expiry
- Delay in consolidating requirements
- Manual maintenance of Records
- Lack of Information at all levels
- No comprehensive quality control

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Objectives of LMS ...

- To stabilize population by enabling the availability of Contraceptives & RCH commodities
- To ensure free flow through effective supply chain
- To reach the needy
- To avoid excess/under supply
- To achieve effective Feed back system
- To identify the service delivery points and the transportation models
- To ensure items availability
- To streamline the process of stock distribution
- To project accurate stock status of IUD's,Condoms,Oral Pills at the PHC's and various sub-centers

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I.T. Enabled LMS

- Operations begin at Family Welfare Department, GOI
- Through the LMC spreads over the each State
- The Process includes
  - ⇨ Effective Stock Monitoring
  - ⇨ Consumption Status at all levels
  - ⇨ Warehousing & Transport Information
  - ⇨ Quality Control
  - ⇨ Information Technology
  - ⇨ Feedback System

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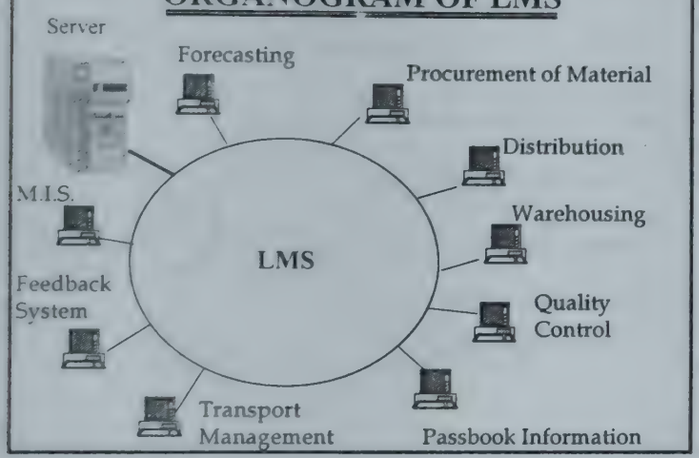
ORGANOGRAM OF LMS



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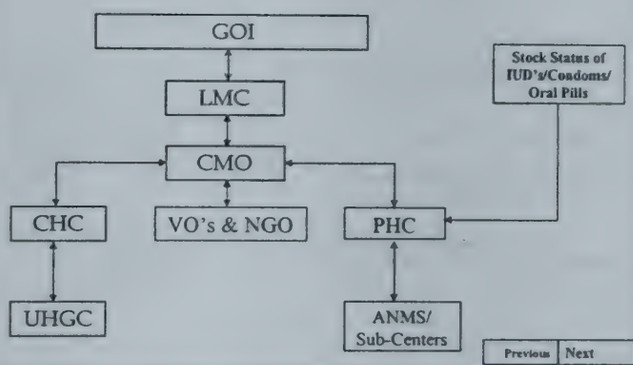
LMS System Flow



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Module Synopsis ..

- ✓ Forecasting System
- ✓ Procurement of Material
- ✓ Material Distribution
- ✓ Warehousing System
- ✓ Quality Control System
- ✓ Passbook Information System
- ✓ Transport Management System
- ✓ Feed back System
- ✓ Management Information System (MIS)

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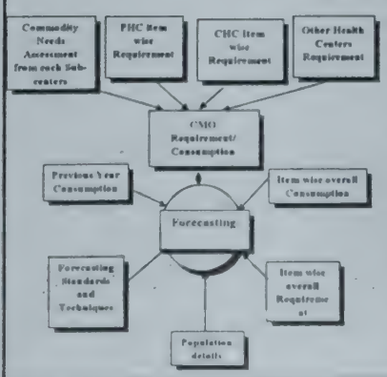
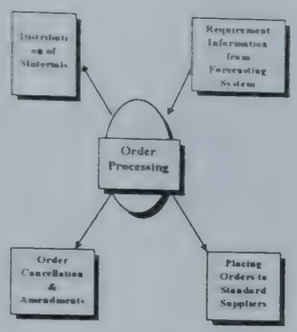
Data Flow Diagram of Forecasting



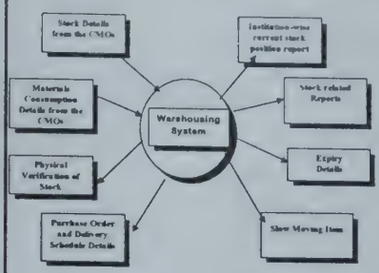
- ➢ Commodity needs assessment which is primarily done at each Sub-Centers plays an important role in forecasting
- ➢ The current year requirements will be ascertained from previous years consumption details
- ➢ CMO's will send the requirements to the LMC
- ➢ The LMC will consolidate the requirements submits to GOI
- ➢ All inputs relevant to consumption are taken to decide requirements
- ➢ A module will be incorporated at GOI for rationalizing the requirements

Data Flow Diagram of Order Processing



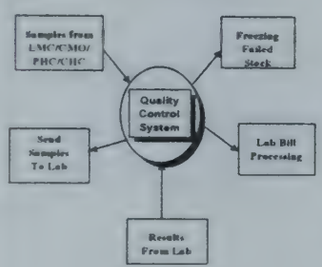
- Based on the requirements, the total requirement at GOI is worked out
- As per the accepted values orders will be placed against the supplier with delivery schedule
- Orders will be generated based on the volume of requirements against season, stock out etc.
- System will pass automatically the delivery schedule copy to each of the LMC for its planning

Data Flow Diagram of Warehousing System



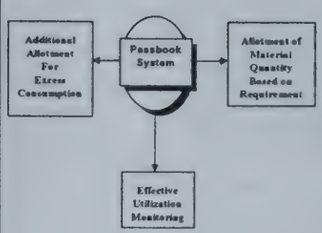
- Commodity wise stock on LMC
- Inward / outward stock
- Receipt note for inward outward
- In built system of tallying
- Rationalizing the requirement pattern
- Warehousing integrates with CMO transaction

Data Flow Diagram of Quality Control System



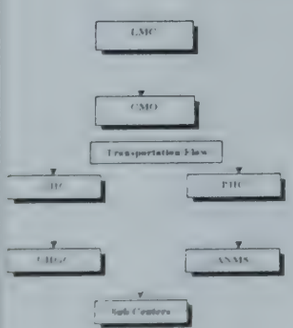
- Samples from PHC/CHC/CMO will be sent for Q.C
- The samples that are sent to lab are maintained by LMC Q.C.
- Upon failure, the stocks will be freezed in all through the chain.
- Frozen stock details maintained separately
- Lab Bill processing details will also be maintained in the system.

Data Flow Diagram of Passbook Information System



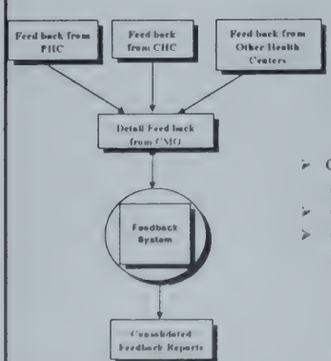
- Passbook may be introduced in CHC's & PHC's where quantity allotted will be maintained
- Excess allotment will be perused separately
- A Seasonal commodity wise utilization will be worked out for better search
- This helps in monitoring the distribution of Materials upto PHC's for effective Management Control.

Data Flow Diagram of Transport Management System



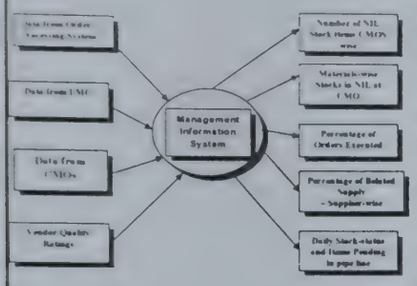
- Logistic Management Cell receives stocks for the state
- Based on requirements stocks will be transported through transport operators
- To systematize the delivery reach for flawless logistics, private transportation system may be very suitable
- The transport operators will be given with the format for obtaining stock transfer details from each of the supply chain
- Each of the CMO delivery details will be summed up for a comprehensive stock monitoring

Flow Diagram of Feedback System



- Getting Feedback from the Institution at each level
- Consolidating the feedbacks
- Generating reports to help the management in decision making

Data Flow Diagram of Management Information System



- Data from various CMOs,PHC's and CMC's and other health centers will be consolidated for Management Decision-Making purpose
- Such data obtained will be grouped in the form of reports
- MIS reports can be generated on a Monthly, Quarterly and Annual basis
- Provides timely information about items from various CMO's and its sub-centers

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Recommendations

System Improvements :

At GOI :

- **Requirements based on actual consumption**
- **Budgeting**
- **Organized Distribution**

At LMC :

- **Effective Stock Monitoring**
- **Avoidance of Time Expiry**
- **Effective Quality Monitoring**
- **Consolidating the requirements can be made easy**
- **Discrepancy in Manual records can be avoided**
- **Transparency in the Entire system**

Continued...

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Recommendations

System Improvements :

- **Private sector participation is very essential for effective distribution of contraceptives**
- **Large industrial units and chambers of commerce can be invited to contribute to the efforts of family planning**
- **Private hospitals, nursing homes can be utilized for providing family planning services**

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COST OUTLAY

	Rs. In Crores
• Non-Recurring Costs	
a. Building of 3 LMC Warehouses 200 Sq.mts. @ 7000 per Sq.mt	4.20
b. Computer Hardware & system software 70 CMO's @Rs.4.00 lacs.	2.80
c. Software development and Implementation 3-LMC's anf 70 CMO's	1.00
d. Training and Development	0.20
Total Non-Recurring cost	8.20
2. Recurring Costs	
a. Personnel	1.20
b. Transportation	2.00
c. AMC's Warehouse maintenance, onsumables	0.90
Total Recurring cost	4.10

Total cost for establishing LMS for U.P is about Rs.12.30 Crores

Section 14

Text of address by

President, FPAI

EMPOWERED ACTION GROUP [EAG]
FIRST BUSINESS SESSION: 18TH JUNE 2001
VIGYAN BHAVAN, NEW DELHI

Comments submitted by

Dr. Nina Puri
President, Family Planning Association of India

Hon'ble Minister, esteemed delegates,

As a representative of a Non Government Organization liberated from the barbs of bureaucratic, hierarchical custom, I would like to first thank the Minister for his presence and punctuality in addressing with political persuasiveness, laced with patience and politeness issues concerning people and population.

Privileged to represent perhaps the largest and oldest NGO in the country working in the sphere of Reproductive Health and Family Planning, I cannot however desegregate myself from the fact that I am the daughter of a civil servant, daughter in law of a politician, wife of a businessman, mother to a one child formula – son – [no sex determination in this case], and grandmother of two lovely girls, and myself a voluntary social worker for the past 35 years.

The only reason for inflicting this bio-data on you is to illustrate the matter of 'convergence', which is our 'laksha' – objective for today's conference.

One is extremely happy to cull from the well prepared document a realization that we can no longer work with a formula of 'one-size fits-all' and indeed today with all the data available to us compiled for consideration in facilitating policy formulation and implementation, it seems very clear that we are not taking up issues and programmes by looking through a telescope focusing on a larger measure of ground reality.

It is indeed a great honour and privilege to be included in this Empowered Action Group along with Alok Mukhopadyay of VHAI in the spirit of partnership with Government. Speaking to this august and enlightened audience is like focusing a lamp on a hundred light bulbs, however, having been given this space to air a few comments and thoughts on specific issues related to the agenda, I share the following:

Role of the EAG:

This indeed is an extremely challenging maiden venture which I think can lend itself to assist in providing impact through development schemes for the people and the community, if all constituencies in all honesty accept this monitoring, facilitating and financing role for this group.

Addressing the member State Governments and Departments of the Government of India:

Centre-State coordination in relation to the question of population stabilization has been a kind of Achilles heel. Here again if we first and foremost own our responsibility to the people and the community, then the list of outcomes on the top five issues in the State after the resource gaps are identified can develop into a healthy process of implementation.

Governance Issues:

It has been very convincingly brought out through an illustration in facts and figures that the shortage of resources is not the primary hurdle for a smooth sail. The very reflection of unspent monies demonstrates that we have to look elsewhere for effective implementation. Working in valleys and peaks with the added qualification of our personal egos playing havoc, has really not helped in building up confidence of the individuals and the community, for all that is poured in as resources into areas of socio economic development – primarily health, education and infrastructure.

Decentralization and Convergence: Key to Management Reform:

Here we have to really understand the very meaning of convergence between the two areas of population and development. When we speak on the key strategic schemes articulated for this purpose – i) Decentralized planning and programme implementation; ii) Convergence of service delivery at village levels; iii) Public – Private partnership; and iv) Mainstreaming of Indian System of Medicine – it seems to me we are well on the way in diagnosing the problems and hurdles standing in the way of more effective implementation and that is what we need to address.

The bold steps taken for decentralization in Madhya Pradesh is indeed a "B" in the bonnet of the State but whosoever takes initiatives for action is the one who faces the problems and pitfalls, and we do know that in this scheme of decentralization and convergence at the grass-root level there is clear indication that problems have arisen within the 3-tier system at Gran, Janpad and Zilla panchayat levels. Mismanagement and corruption have indeed crept in and that is what needs to be addressed, and something in which this EAG could contribute towards in initiating better management and administration.

Community Needs Assessment Approach (CNAA):

This is an extremely enabling tool to veer away from the target approach, but in reality that is not what is happening and far more inputs have to go into capacity building at all levels to initiate the "HOW" of using this manual.

Public – Private Partnership:

This indeed is an extremely welcome step introduced by the Government in realizing that one constituency cannot delivery the goods in the sensitive area of people and

population. We have in the document a wonderful diagnosis, however, when we invite private partnership, it should not be with a feeling that let us hand out a piece of pie to them, and watch and wait as to how they perform. I think at all levels it should be a joint responsibility in planned action and accountability, which can then lead to some measure of sustainability.

Reducing Maternal Mortality:

Indeed in the 5 States of which we have the figures [Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh and Orissa], it is indeed a matter of great concern that women's health needs far greater focused attention. Schemes and programmes working around ameliorating this ugly blot on our health map should receive the greatest attention from all constituencies. Indeed, it is the multiplier effect of loosing a mother which ripples into the lives of families that can spell ruin.

Adverse Sex Ratio:

On the issue of adverse sex ratios, I would dare to submit that it is the two States of Punjab and Haryana as the latest census figures have demonstrated to us are the main culprits for entrenching the age old mindset for sons through the unholy alliance between customs, tradition and modern technology. For this I wish representatives of these States were here to share with us as to how this practice of sex selection be eliminated. Surmounting this age old desire for sons can indeed be an extremely important intervention for stabilizing population and bringing into greater relief, gender equity and equality.

Mainstreaming of ISM:

Between grandmothers' age old 'totkas' and remedies and the sophisticated surgical interventions with ever increasing advances in the modern medicines and technology, there is a vast area and space for the Indian System of Medicine to bridge the gap for the needs of the individual and the community for services in health, reproductive health, child health and family planning. The document presented to us supported by facts and figures amply demonstrates that in many areas working with the ISM Doctors will vastly help in enhancing the services to the people in the community, which we cannot do in isolation both in advocacy as also the provision of medical advice, and services.

Social Marketing:

Another area alluded to is Social Marketing. Here I am not firmly on terra-ferma and that is, totally confidant that if every service has a price tag then how does we serve the poorest of the poor? We indeed in this case really do need to identify those under the poverty line for services but at the same time realize that providing free service does not mean patronage callousness and rudeness on the part of the provider, and that all human beings deserve the same quality of service and counseling. This in my

experience is one of our biggest weaknesses. Social marketing however is a strategy, which has great potential, should be brought on board more activity even for expanded services, but with a note of caution.

Gender Sensitivity:

This is something that is again an area, which cuts across all departments and constituencies, and whilst formulating policies and programmes gender conceptualized in the right spirit and understanding must be mainstreamed.

Finally we must work within the soft belly of action and that is honesty of purpose, transparency, integrity and above all accountability, only then will words translate into deeds, and we can gain confidence and respect of the people, the community, and the nation.


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